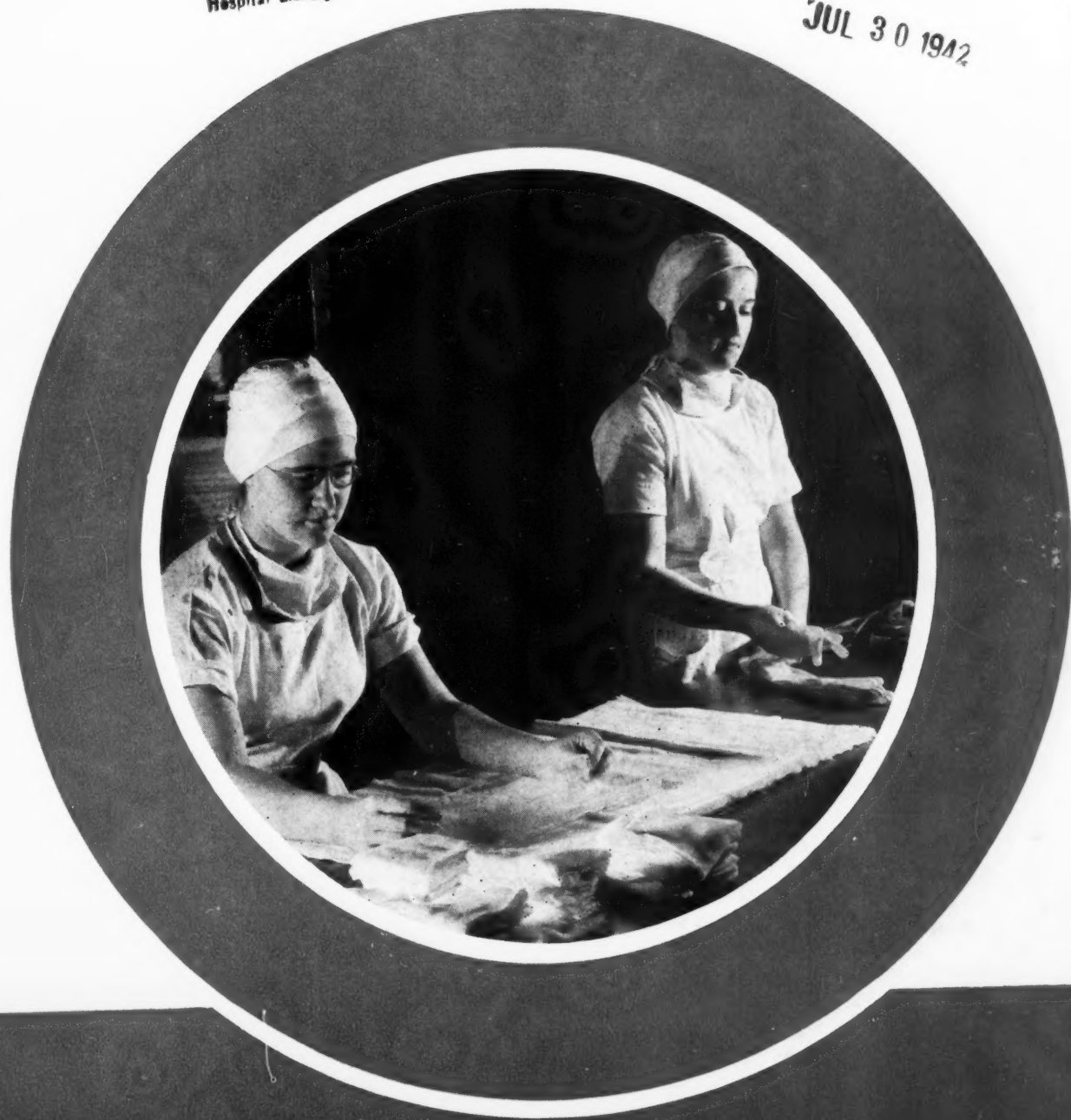


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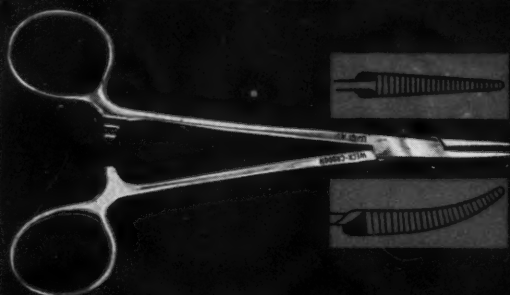


the
MODERN
HOSPITAL

VOLUME 59

AUGUST 1942

NUMBER 2



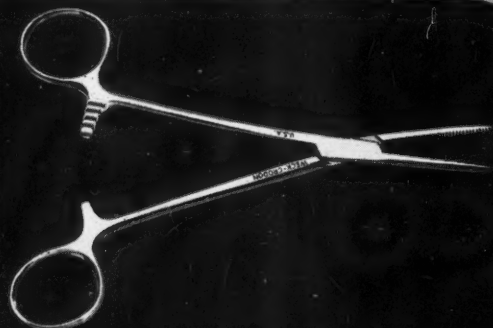
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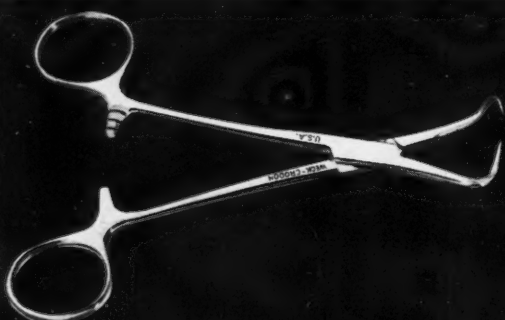
Then there is E for ECONOMY



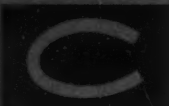
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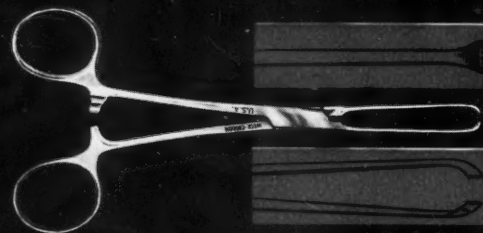
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four of a kind!

Two "fours of a kind" are shown above — pictorially you see four of the many new MADE-IN-AMERICA Weck surgical instruments. Under each are prices in Stainless steel or Crodon-Chrome-plated. Also we repeat that other "four of a kind" which is a part of every Weck sale — of every Weck delivery: W — for WECK WORKMANSHIP; E — for ECONOMY; C — for CONFIDENCE which is assured when you deal with this 50-year old house; and K — which stands for QUALITY — one only — the FINEST.

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Just in Passing—

WITH personnel shortages more acute than at any previous time during the past quarter century, hospital administrators will welcome two special features in the September issue. The first shows possible short-cuts in hospital accounting while the second outlines the place and function of time and motion studies in hospital personnel administration.

HAWAII'S newest hospital will be on display in our September pages. Since we can't go to Hawaii now, the journal will bring Hawaii to us.

THE new naval medical center just outside Washington was completed just in time for the tremendously increased responsibilities that have fallen upon the shoulders of the Medical Department of the Navy. Come tour it with us in next month's issue.

for BETTER STAFF WORK

Your department heads need information in this issue. You can call it to their attention easily with the coupon below. Just tear it out and paste or clip to the cover of the magazine.

READ AND PASS ALONG

See page Noted

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The Modern Hospital

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Normal Life

● The administration of Insulin is no longer a serious problem. Thousands of diabetic children have learned to administer it to themselves. In 1914, a child with this disease had an average life expectancy of 1.3 years. Today the diabetic child grows up, goes to college, graduates, gets a job, and proceeds to lead a normal life. Thus diabetes today need not be an appreciable handicap.

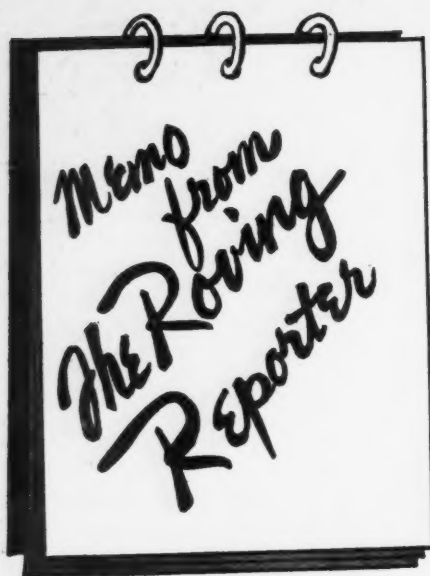
Eli Lilly and Company has published a book entitled *Diabetes Mellitus* which outlines approved methods of dietetic management and the use of Insulin. Free copies will be sent to members of the medical profession on request.

* * *

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Take Your Choice

Here is an idea that might well be added to any list of "Conservation Considerations." It has to do with the conservation of paper used in preparing annual reports. Instead of distributing complete reports to those who have no use for them and who will not read them, why not prepare, in addition to a full review of the year's progress, an abstract statement covering only the high points and give each individual an opportunity to indicate his preference?

Massachusetts General Hospital is doing precisely this. A postal with return card bears a statement signed by Dr. N. W. Faxon, director, explaining that two reports are available, a complete statement containing 250 pages and a smaller edition of 58 pages.

"It is the desire of the hospital," this statement reads, "to place in the hands of all interested persons copies of the annual report. Because of the shortage of paper and because of rising costs of operation the hospital is naturally desirous of using every possible economy. If you desire the full annual report, we shall be glad to send it to you. If you would like the smaller report, we shall be glad to send that."

In addition to accomplishing the original purpose of conserving paper and reducing costs, the return cards may prove a gauge of public interest in such annual statements, which has long been a matter of debate. They might even indicate greater possibilities for conservation of paper stock another year.

Two Answers to a Problem

At least two institutions visited recently report a satisfactory solution to the problem of adjusting intern schedules to meet the shortened courses in medical colleges.

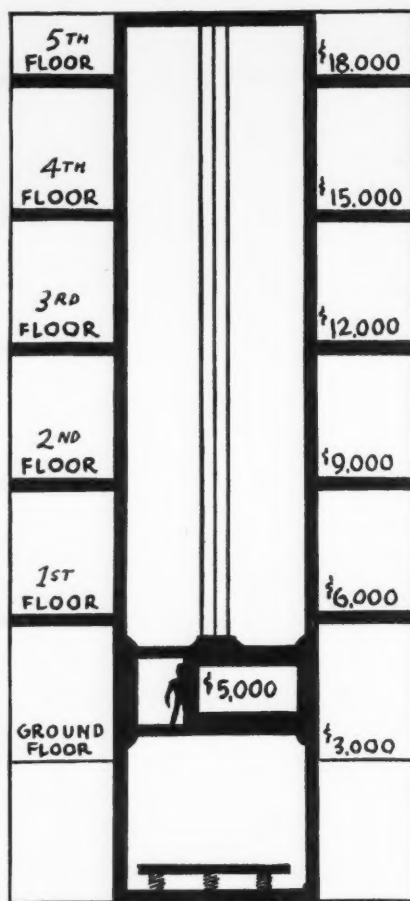
In one of these the young doctors spend the last two or three months work-

ing in the out-patient department where they meet the patient at the door and follow him through under the supervision of the chief of service. This gives them practical experience in the things they will have to do after they leave the hospital. Seminars conducted every two weeks provide opportunity for general discussion in the program that is designated as the "whole patient method."

In the other institution the older interns who are nearing the completion of their training serve in the capacity of residents. This arrangement has been successful in avoiding conflict with the incoming group and has worked out advantageously for doctors and hospital alike.

Elevator Going Up!

The younger doctors are joining their units at the camps or on the fighting front and the seniors are being called



Shadyside's new elevator fund rises.

upon to carry the extra burden of hospital work.

Shadyside Hospital, Pittsburgh, feels a little guilty when these older doctors sometimes have to climb two or three flights of stairs because an ancient elevator is either balky or tied up at the moment.

No complaint need be filed against

the elevator for it, like many of the senior doctors, has seen more than thirty years of service in the hospital's original building. Its weariness is understandable.

Dr. T. I. Cottom, the superintendent, recently inaugurated an elevator fund. The first gift of \$5000 from the Carnahan Trust brought the fund out of the basement and now the new elevator fund is climbing, as evidenced by a dramatized drawing that registers the progress of the new car until it reaches the top floor.

The chances seem good that, despite other demands on their money, the patrons of Shadyside will keep the elevator fund going up so that it won't often be stuck between floors.

Report in Modern Dress

Something new in hospital reports crosses the desk of your Roving Reporter! At first glance it appears to be a copy of *Life* with its pictorial cover showing a nurse examining a 50 cc. syringe. But substituted for the name of the magazine are the words "Annual Report," and beneath the picture, the name Monmouth Memorial Hospital, Long Branch, N. J.

That no misunderstanding may prevail as to the source of the idea, the following credit line is included: "On the theory that imitation is the sincerest form of flattery, we hope and are sure that *Life* will forgive this obvious plagiarism."

Six pages that follow contain interesting information about hospital service, each one more interesting than the other, interspersed liberally with pictures. The usual reports are included but how different they appear when condensed into a few brief paragraphs, set in readable type! "The President Speaks," for example; "The Director Reports"; "The Treasurer Figures." Effectively told, all of them, but brevity is a dominant characteristic.

To tie in the hospital with the war program, the back cover pictures the building prepared for a blackout. Nurses are shown pulling the dark curtains, a scene in the stockroom reveals piles of reconditioned beds ready for emergency and an exterior view discloses the hospital blacked out completely during a recent test raid, its darkened windows silhouetted by the photographer's flash bulb.

Your Roving Reporter found himself laying the folder aside with regret, but with thanks to Otis N. Auer, superintendent, for the privilege of reviewing a typically modern hospital report. There is such great need to tell what goes on in hospitals these days as effectively as does Monmouth Memorial.

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TAL



This Army has been "mechanized" for years!



To millions of Americans, this familiar insignia symbolizes an unfailing response in time of need—a faithful guardian of public health. Now, with our country steeled to defend the fruits of democracy against aggression, the task of maintaining a physically-fit America takes on even greater significance.

In this emergency, a genuine but perhaps unconscious tribute is being paid the medical profession. America has taken for granted your ability to maintain the Public Health during the trying days that lie ahead. Keeping that trust requires not only your professional

skill but an adequate supply of the materials you use.

If Intensifying or Fluoroscopic Screens play an essential part in your work, Patterson has an important message for you. Our manufacturing facilities are being devoted entirely to the demands of the military and civilian health services. Our exhaustive testing and research program is being maintained. Vigilance over raw materials has been increased. As a result, you can be certain of obtaining the same degree

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Small Hospital Questions

For Complete Patients' Charts

Question: What information is it necessary for the nurse to record on patients' charts?—S.V.S., Mont.

ANSWER: The nurse's notes should record what she has done and what she has observed in the nursing care of the patient. Usually, temperature, pulse, respirations, stools and urine are recorded on the graphic chart and need not be repeated in the nurse's notes.

The standard form for the nurse's notes has three columns—the first column is for the hour at which the treatment or medication was given and the observation made. In the medication and diet column each dose of medicine and all diets are recorded. Medicine given is identified by the prescription number and diet by a note referring to the complete diet order.

The column for nurse's notes occupies about half the form to allow the nurse to record her observations that have a bearing on the patient's reaction to treatment and the progress being made. It should always be remembered that the notes cover the observations of the nurse from minute to minute as she cares for the patient.—MALCOLM T. MACEachern, M.D.

Arousing the Indifferent Trustee

Question: What can be done about board members who never come near the hospital but whom you do not wish to drop from the board?—M.C., N.Y.

ANSWER: Perhaps your indifferent trustee has a friend on the board through whom you might work to arouse his enthusiasm. Ascertain in what direction his interests lie and make him feel that the hospital needs his help in meeting its many problems. Give him a specific job to tackle; encourage him, yes, make him feel his importance, for he is important—every trustee is important, too important to remain inactive. And if at first you don't succeed, try, try again.—RAYMOND P. SLOAN.

Radiologists' Compensation

Question: From the standpoint of the hospital, which is the more satisfactory financial arrangement to make with a radiologist—giving him a percentage of the net income or renting him space in the hospital?—E.G.D., S.D.

ANSWER: The most satisfactory financial arrangement that a hospital can make with a radiologist, in our opinion, is a percentage of net income after deducting x-ray department employees' salaries and supplies. This percentage varies with the size of the hospital, the amount of space used, the total cost of equipment

Conducted by Gladys Brandt, R.N.,
Children's Free Hospital, Louisville,
Ky.; Jewell W. Thrasher, R.N.,
Fraser-Ellis Hospital, Dothan, Ala.;
William J. Donnelly, Princeton Hos-
pital, Princeton, N. J., and others

and the income of the department. The amount of income depends on the number of out-patients and whether or not the department acts as the x-ray center for the community.

The percentage to the radiologist must be larger in small hospitals in order to attract a qualified radiologist. If the income of the department is large enough to justify a reasonable compensation to the radiologist, then the percentage can be stabilized.

In the larger hospitals the usual percentage of net income, where the hospital owns the equipment, is on a fifty-fifty basis of net after the deductions, noted above, with an adjustment for uncollectible accounts; or the calculations are strictly on a cash collection basis. Such an arrangement is better than a percentage of gross as it encourages the radiologist to have an interest in the direct overhead of the department, such as salaries and supplies.

Such a plan is superior to a strictly rental arrangement because an x-ray department must have expensive equipment. It is difficult for an individual to finance equipment and, if so financed, difficulties arise in replacing such equipment to the satisfaction of the hospital, as x-ray equipment has a high depreciation and the department must keep step with the recent advances in this scientific field.

A purely rental arrangement with the radiologist generally does not work to the advantage of the hospital as the radiologist's idea of rent to be paid is usually gained from the rates he would pay in a general office building. He usually does not consider that the hospital building is a specialized unit with four or five times more service area than a general office building. Also, the construction cost of a hospital building is far in excess of that of a general office building.

Consideration should also be given to the fact that in a hospital x-ray department the radiologist obtains all of the professional work in the building. The professional standing of the radiologist is an asset to the hospital. Therefore, the

percentage basis, as outlined above, is a cooperative arrangement which works for the best interest of the patient, the radiologist and the hospital.—R. E. HEERMAN.

When Charity Is Compulsory

Question: Does a private hospital remain within its legal rights when it refuses to admit a patient who has been given first aid and who requires hospitalization but is unable to pay for it?—W.M.S., Ga.

ANSWER: After rendering first aid, a private hospital ordinarily is under no legal obligation to hospitalize a patient. However, it cannot abandon the patient thereafter or refuse imperative hospitalization, unless reasonable arrangements are made for his immediate care. To do otherwise would be a breach of a legal duty which the hospital undertook when it agreed to give emergency treatment. In the recent case of *Meiselman v. Crown Heights Hospital* (285 N.Y. 396, 34 N.E. 2d 370), it was held that the inability of the patient to pay for further care is no defense in an action for damages for "prematurely and willfully" abandoning the case "while the patient was desperately ill."—EMANUEL HAYT.

Daily Disposal of Refuse

Question: What provision should be made for garbage disposal in a 25 bed hospital located in a small village in which the garbage is collected weekly?—N.S., N.Y.

ANSWER: Whether garbage is collected weekly or daily makes no difference since soiled dressings must not be thrown into garbage that is collected by the city. If there is not an incinerator some provision has to be made for burning this refuse on the hospital premises. Heavy wire baskets are probably the cheapest and most practical receptacles to be used in this method. Swill can usually be disposed of by an arrangement between the hospital and some near-by farmer and can be collected daily.—JEWELL W. THRASHER.

Child Visitors Discouraged

Question: Should children be allowed to visit parents or other patients in a tuberculosis sanatorium? Should there be an age limit?—I.L.H., Wis.

ANSWER: No. Neither a sanatorium nor a hospital is a safe place for children. One of the chief objects of every tuberculosis sanatorium is the isolation of the tuberculous and the breaking of contacts with children. This object is nullified by permitting children to visit patients.

The lowest age limit should be 14. In some institutions it is 16.—MAXIM POL-LAK, M.D.

LOOKING FORWARD

"Make No Little Plans"

NOW, in the midst of war, we should plan for peace. And in this planning it would be well to ponder the oft-quoted words of Daniel H. Burnham, the noted city designer:

"Make no little plans. They have no magic to stir men's blood and probably themselves will not be realized.

"Make big plans; aim high in hope and work, remembering that a noble, logical diagram once recorded will never die, but long after we are all gone will be a living thing, asserting itself with ever growing consistency. Remember that our sons and grandsons are going to do things that would stagger us.

"Let your watchword be order and your beacon, beauty."

Burnham's famed advice is as applicable to planning for the people's health as to the planning of metropolitan areas.

The Personnel Shortage

WE HAVE been hesitant to tell the public fully about the serious personnel shortage that faces all hospitals. This hesitancy is understandable; we did not want to appear to be making excuses or to shake public confidence in our ability to provide needed care.

Now, however, the situation is becoming so acute that we must take the public into our confidence. Even with the help of volunteers and with all possible readjustments in personnel that we can effect, it is obvious that we cannot longer expect to maintain all of our service standards. The shortages in nurses and physicians are the most dramatic but serious problems are also being faced in the housekeeping and dietary departments. Administrators and department heads are going gray-headed at the enormous turnover.

Let's not try any longer to hide the facts. Our prospective patients should know that when they come to the hospital they will not be able to obtain many of the luxuries to which they have been accustomed. The wastebasket may not be emptied as often; flowers may not be put in water as quickly; there may be hitches in the food service; between meal nourishments may

not be provided to those who do not need them. Some persons may actually be turned away.

The warm cooperation of patients should be solicited. If patients understand that we are doing the best we possibly can to stretch the available personnel hours over the total requirements, they can lighten our load appreciably.

Medical, nursing, hospital and Blue Cross organizations might well undertake immediately a national cooperative educational program to enlist the understanding and assistance of the public in helping health agencies to meet the most urgent needs during this crisis. For such a program they need not apologize. The personnel shortage is the result of war, not of the negligence of any particular group.

Where to Decontaminate?

IN A war of surprises, the use of poison gas must be anticipated. This requires the preparation of gas decontamination stations. Where should such stations be located?

It is the sober judgment of several hospital administrators who have taken a leading part in civilian defense activities that it would be a serious mistake to put these stations in hospitals. In case of a gas attack, hundreds, perhaps thousands, of people would be contaminated and other thousands might be terrorized by the fear of contamination. Yet only a few persons per hour can be handled by decontamination stations. Large crowds might easily be milling around outside the stations trying desperately to break in before the gas affects them.

If these people break into a gas decontamination station, that is admittedly bad. But if they break into a hospital and contaminate the patients and especially the personnel that is far worse. In such a crisis, hospital employees are even more important than ever before. They must be protected from contamination so that they can continue to carry their services to the greatly increased numbers of patients. Decontamination teams may, if desirable, be sent from the hospitals to the stations that may be a block or a mile away.

Actually, is decontamination a hospital job at all? Is it not really a civilian defense responsibility for which especially trained chemists are more effective than

physicians and nurses? Only after the victims have been decontaminated and found to be suffering from gas injuries should they be brought to the hospital.

Recently, the Director of Civilian Defense issued some excellent practical suggestions regarding gas defense. It would be well for him to supplement these statements now by a clear definition of the initial responsibility for decontamination.

Let's Make Conventions Count

THE Office of Defense Transportation has appealed to all citizens to restrict voluntarily all conventions and other activities that will require transportation facilities. There is talk of compulsory control of conventions but, to date, it appears to be merely talk.

The federal government has so generally recognized the importance of medical and hospital organizations that it is doubtful if a compulsory restriction would apply to the A.H.A. convention. Certainly, in this trying period it is more important than ever that hospital people get together at least once a year to exchange information and work out the soundest possible policies.

The need for having one significant national convention, however, does not justify holding many others. It would be a statesmanlike move for the leaders of the A.H.A., the A.C.S. and the state and regional hospital associations to set up immediately a joint committee to work out methods of reducing the number of conventions and increasing the quality and content proportionately. Each convention that is held should be so crammed with valuable information and inspiration that everyone in attendance will return home with renewed ability and faith to do his job well.

An Annoying Minor Racket

"GIFTS or donations should not be solicited from business houses on the basis of making a return for business granted."

That is the considered judgment of the American College of Hospital Administrators, the American Hospital Association and the Canadian Hospital Council as expressed in the code of ethics adopted by all three bodies.

Yet hardly a day passes that the manufacturers and jobbers of hospital equipment and supplies do not receive one or more letters substantially as follows:

"Because of the contacts that you have had with _____ Hospital in supplying it with merchandise, I know that you will be interested in the news that we are building a new structure that will increase our capacity from 200 to 400 beds. A campaign to raise \$400,000 for this project will be conducted.

"We are hopeful that you will find it possible to aid us in reaching this quota. The hospital trustees, who not only serve without salary but continually

give of their personal means to keep the hospital on the job, feel that all those with whom the institution has business relations will want a part in this urgent undertaking. I am enclosing a subscription card with the earnest plea that you return it promptly with a subscription that represents your maximum ability."

The unfairness of such appeals has been frequently mentioned in these columns. Since such subscriptions are and must be added to the cost of doing business, the only alternative open to the subscribing firm is to add some further markup to the cost of goods. Thus, the ethical hospitals are forced to contribute to the campaign funds of those who do not follow the standard code of ethics.

Furthermore, the hospital that has received a large contribution from a company is probably unlikely to scrutinize as carefully as it should the bills of that company or to compare prices and quality with those available from other sources.

Equally unsound is the attitude of the hospital dealer or manufacturer who, in response to a complaint about the quality or price of his merchandise, sends an invitation to dinner or a handsome desk ornament.

Corrective measures can be taken either by the various hospital associations or by the Hospital Industries Association. It will be interesting to see whether any group has the requisite power and courage.

Lay Administrators in the Army

THROUGH the efforts of the American College of Hospital Administrators, the Surgeon General of the U. S. Army has liberalized the provisions for commissioning lay hospital administrators in the Army's Medical Corps. Commissions ranging from second lieutenant to captain, depending upon experience, ability and general qualifications, are now offered, although only a limited number will be available to lay administrators. They are for service mess officers, medical supply officers, adjutants and assistant adjutants, assistant executive officers and assistant hospital inspectors.

Hospital administrators under 30 years of age, whether subject to draft or not, may be inducted into the Army and may apply for assignment to the medical department to attend one of the medical administrative corps' schools. After satisfactory completion of the three months' course, a commission will be granted. Men in class 3A may ask for induction into the Army for the special purpose of being assigned to the medical department and sent to the school. Administrators over 30 may apply directly to the Surgeon General's office for commissions. If accepted, they will be given one month's instruction.

This willingness to recognize the technical experience of lay hospital administrators, while it does not place them on a par with medical administrators, is a distinct gain over the previous attitude of the Army. Congratulations to the A.C.H.A. are in order.

You can

SERVE

your country by

1. TEACHING NUTRITION TO YOUR TOWNSPEOPLE
2. KEEPING UP MEDICAL RECORD STANDARDS
3. CUTTING NURSING COSTS AND HOURS

TEACHING NUTRITION

MRS. BENJAMIN ALEXANDER

Former Dietitian, Beth Israel Clinic
Boston

IN THIS time of grave need hospitals are expected increasingly to take their place in preventive medicine. Since nutrition is of paramount importance in the maintenance of health, hospitals must waste no time in instituting measures to improve the general nutritional level.

In each hospital, in each community, a vigorous nutrition program should be formulated and promoted. In this task, hospital administrators will find invaluable assistance in the food clinic, which has for many years been in the forefront of the struggle against malnutrition. Evolved to meet conditions that resulted from the last World War, the food clinic has gradually grown until now, in a new national crisis, it assumes great potential significance.

First, the hospital should make every effort to educate that large part of the community that yearly comes within the hospital walls; second, it should cooperate in nutrition work with other agencies.

Although the food clinic's first function is to assist in the dietary

treatment of the ambulatory patient by interpreting the doctor's food prescription in terms of the patient's special environment, the clinic has gradually expanded its service in order to make nutrition a vital factor throughout the entire community. In this work the first problem is to impress upon every patient and every member of the out-patient department the fundamental principles of nutrition.

Historically, the problem of teaching the patient was met first in the group referred directly to the food clinic for special therapeutic treatment. Later, methods were developed for educating the much larger group that comes to the out-patient department but not to the food clinic.

All patients referred directly to the food clinic are given constructive instruction in elementary rules of good nutrition. To the food clinic dietitian a therapeutic diet is primarily a modification of the normal

diet; this concept is passed on to her patient. Emphasis is always laid first on the essentials of normal nutrition, the food constituents and the amount of each included in an adequate diet, second on the changes that must be made in the normal diet to meet the demands of the pathologic state and third on the necessity for supplying normal requirements despite the limitations of the special diet.

Upon each patient, therefore, is impressed not only the rules for his particular diet but also the fact of his personal responsibility for providing his body with the elements essential for adequate nutrition. To the food clinic patient, diet does not mean merely a temporary treatment for a pathologic condition; rather, diet becomes infused with new significance, a permanent part of everyday living.

Because of this stress on the requirements of normal nutrition, much of the food clinic teaching is applicable to the patient's family and friends. The patients go forth with

new ideas which, imparted to mothers or children or associates, help to correct poor food habits in many homes.

For reaching out-patients who are not food clinic patients, the food clinic has borrowed the technics of the health educator. This aspect of the work falls roughly into two separate categories: exhibits and class work.

For exhibits the clinic dietitian stakes her claim on some strategic wall of the out-patient department, one centrally located in the path of travel of a large percentage of out-patients. This spot becomes known as the exhibit center and is sought out by the patients, who grow to appreciate the information thus obtainable.

Posters, pictures and real or wax foods are utilized to help the patient visualize all the aspects of good nutrition—meal planning, the nutritional values of protective foods and the importance and function of min-

Group instruction in nutrition habits is another means of health education which the food clinic practices and which it can expand to fulfill the demands of any large scale hospital nutrition program. This type of health education is often carried out through meetings with mothers of the out-patient group. Combining lectures and discussions with simple and appropriate entertainment, the clinic dietitian or her health education assistant instills new ideas in groups of women who, in their function as homemakers, are responsible for the health of a significant proportion of the population.

Children, too, urgently need instruction in the importance of good food. Many who are not influenced through exhibits or through direct contact with the food clinic may be

Eager to contribute its experience to the people is the food clinic.

For many years now the food clinic has sought to give to doctors and medical students some training in applied dietetics, with particular emphasis on the economic, psychological and sociologic aspects of dietary treatment.

Other types of students benefit from the instruction the food clinic provides. Dietitians in training and graduate dietitians, students of home economics and students of social work, all come to the food clinic for a type of teaching that is obtainable nowhere else in the hospital and that is of fundamental importance when these men and women go forth to practice their chosen professions in the towns and cities of the entire country.

Within the past few years, social institutions have grown to appreciate the fundamental relationship of nutrition to their work but many have not been able to afford the services of a full-time nutrition worker. It is to these particularly that the food



erals, vitamins and other food constituents.

The facts are stated in simple phrases, easily understood and easily remembered, while free leaflets afford the patients an opportunity to take home some reminder of the exhibit's message. Related pictures in other corridors of the out-patient department reenforce the clinic teachings, at the same time brightening the walls and diverting the patients as they pass.

reached by classes in pediatric, eye and dental clinics. The class lessons, worked out by food clinic workers and health educators, are especially adapted to the age level of the audience and are invaluable in any hospital health program.

Although the classes, meetings and exhibits are planned primarily for patients, the teaching also reaches others in the hospital (physicians, students, social workers, employees, volunteers and visitors).

clinic dietitian has been of service. In some instances, she has acted solely in an advisory capacity. Directors of child welfare agencies, of free summer camps and of family agencies turn to the food clinic dietitian whenever there are problems in which nutrition plays a rôle, because the food clinic worker comprehends the intricate relationship between food and environmental factors and has daily practice in solving the problems that arise as a result.

In some cases, the food clinic dietitian has even served as a part-time worker for an agency that has no nutritionist of its own. Many settlement house workers, learning that the food clinic dietitian understands the type of person who uses the facilities of the settlement house, have found in the food clinic someone to supervise the settlement's nutrition program.

In Boston, the Y.W.C.A. has used food clinic dietitians to develop a nutrition project. Another Boston institution, the Burroughs Newsboys Foundation, has an intensive night nutrition program which has been

carried out entirely by food clinic dietitians.

Public agencies, as well as private, often desire advice in nutrition problems but are unable to afford their own nutritionists. Here again, because of her understanding of the problems of the low income group, assistance is sought from the food clinic dietitian for help with materials, with posters and with budgets. This places her in a position to render service to the cause by insistence upon adequate food allowances to the recipients of relief.

The clinic dietitian has also worked with the authorities of the

Surplus Marketing Administration. The aim of this cooperation is to ensure that those who receive food stamps will recognize their value, will plan for their use by careful budgeting and will learn what foods to buy. Furtherance of this project can bring to a large new section of the community important training in the relation of nutrition to daily living.

All these services, all the training and background of its workers, the food clinic now offers to the hospital administrator. It is ready and eager to contribute its experience to any hospital program for the community.

MEDICAL RECORDS

SISTER M. PATRICIA, O.S.B.

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WHAT of the record library and its equipment in time of war? This department varies from a small section of the hospital's business office to a separate department of several rooms. The factor of size should be in direct ratio to the size of the hospital. The important point is that location and equipment be adequate for obtaining good medical records with the least effort and expense.

The present emergency forces us to face the fact that not only steel but paper, rubber bands, erasers and all types of office supplies will be scarce if not entirely out of reach. Yet the American College of Surgeons expects to find the present standards for medical records maintained in all approved hospitals. From the standpoint of civilian defense the standards should be kept up, the College believes, because lowering of the quality of medical records usually indicates lowering of the quality of scientific service.

The first step in the right direction has been taken when the record librarian and her associates acquire, in addition to their record consciousness, an economy consciousness. Economy of time and materials can be effected if everyone does more careful work, making recopying unnecessary. Attention to loss of motion is another factor. For our steel chart files we can substitute open

shelf filing; for our steel indexing equipment we may have to substitute the heavy cardboard filing trays now on the market.

Though we must have chart forms for the essential data in a complete record, these can be printed on two sides. A careful perusal of any chart form by the record committee and the record librarian would doubtless result in elimination of nonessential data and a consequent saving of space.

More important than equipment for the smooth functioning of the medical record library is the personnel. Many hospitals are unable to get the record librarians they need. In other hospitals record librarians may be doing work that could be done by clerks. At this critical time, the duties of all medical record librarians should be studied with a view to sharing the trained personnel with other hospitals.

A third consideration in any hospital that is meeting the present standards is a definite plan for obtaining medical records. Compared with those written at the close of the first World War, present hospital records are found to show a vast improvement.

Records now are obtained by interns, residents and attending physicians. Sometimes those persons are assisted by medical secretaries. Most administrators are greatly alarmed

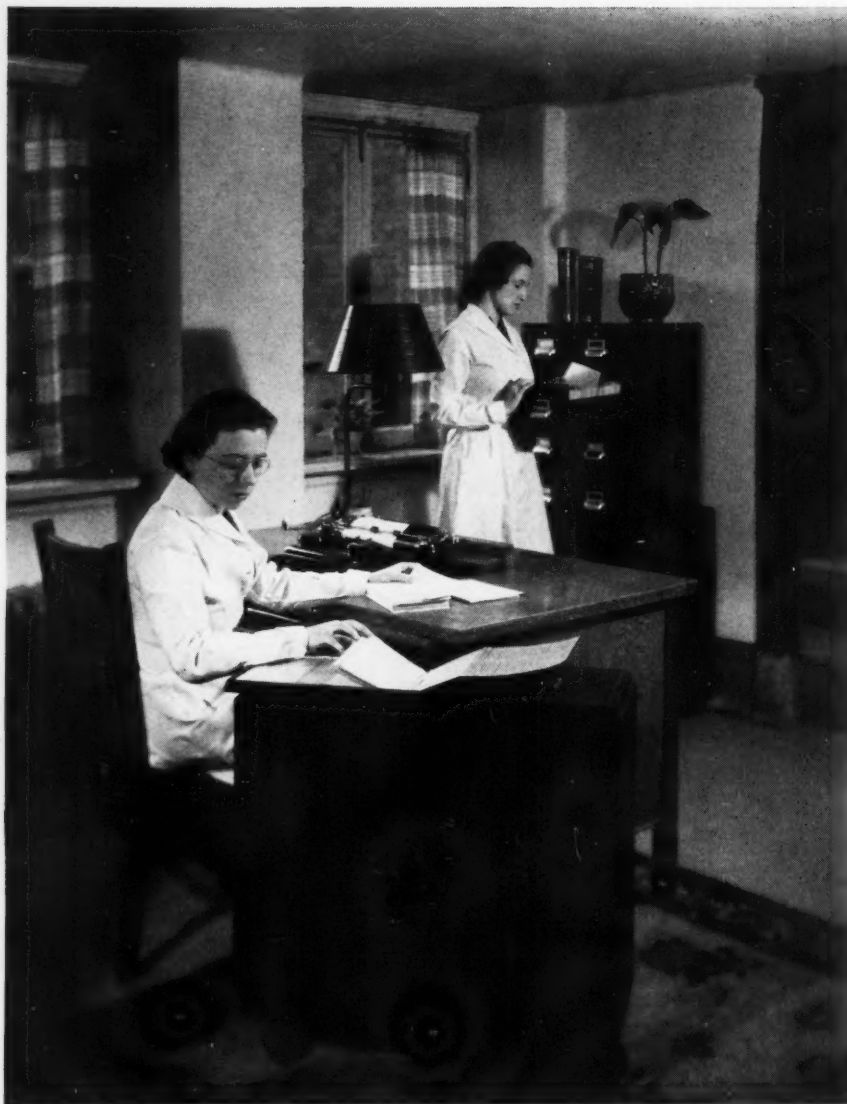
because their hospitals are threatened by or are experiencing the loss of residents and interns. This shortage has placed a heavy burden on the busy physician.

The plan for obtaining adequate scientific records with the least time and effort on the part of the medical staff might include provision for more clerical assistance so that histories, physicals and the other parts of the record may be dictated at the physicians' convenience. The hospital can provide such mechanical aids as dictating equipment to which the medical staff can have access at all hours. Secretarial assistance should be increased.

In accord with civilian defense plans, volunteers are offering their services to hospitals in any capacity in which they can serve. Among such volunteers are many with stenographic training who can be used to advantage in the more technical aspects of securing good medical records or can release the record librarian and medical secretaries for the scientific work.

Maintenance of the "present standards" demands not only quantity but quality in the records. An active medical record committee is essential. There is no substitute. The medical record librarian, by the very fact that she is not a medical school graduate, cannot go beyond the quantitative analysis of the record. Only a physician can judge its quality for only a physician can ascertain whether the record contains suf-

Paper presented at the meeting of the Minnesota Association of Medical Record Librarians, Rochester, Minn., May 25, 1942.



Courtesy, Grant Hospital, Chicago

Medical records of high quality have come to signify a high quality of scientific service. Let's keep our standards high throughout the period of war.

ficient data to justify the diagnosis and warrant the treatment and results.

During the present emergency, with our already busy staff men carrying additional burdens, how can we expect them to continue the careful checking of the quality of our medical records? Yet we must have such qualitative appraisal. The most we can do is to make the task of the record committee as light as possible. The resourceful record librarian will know of many little services, such as obtaining missing signatures and completing progress notes, which she can render to make the committee's work smoother and hence more rapid.

Cross indexes of diseases and operations are the keys to the wealth of scientific data accumulated in our medical records. The present emer-

gency, with its serious threat to the safety of the civilian population, will doubtless bring diseases and injuries that will require careful cross indexing if medical knowledge is to be augmented or even maintained on the present level. The use of an authoritative nomenclature of disease and operation should aid considerably in the collection of reliable statistics on casualties. That medical records are expected to play their part in any emergency is apparent from the attention given this matter in Bulletin No. 1 published by the medical division of the Office of Civilian Defense.

At a recent institute for medical record librarians held at Rochester, N. Y., Olive Johnson read an excellent paper on "Reorganizing the Medical Record Department to Meet Defense Problems."

Here are some pertinent quotations from her paper:

"What records of casualties will we be expected to produce for the patients who have been treated in the hospital? Proof that the patient was hospitalized with a résumé or copy of the record may be requested by the government for pension or disability claims. If histories, physicals, progress notes, discharge summaries, operative notes and consultations are typewritten for the record it will be an easy matter to make an extra copy at the time of writing in case the complete copy will be requested at a later date.

"The office of the Surgeon General states that the following information is necessary for an adequate record of any military personnel treated in civilian hospitals: register number, surname, christian name, army serial number, rank, company, regiment and arm of service, age, race, nativity, service, date of admission, source of admission, cause of admission, additional diagnosis, operations, place of treatment, disposition, date of disposition. . . .

"For those hospitals that have the duplicating admission system it will be a simple matter to run through an extra card for a casualty file and then the detailed identification data will be available on all cases. This should not be confused with the regular patients' index file but will be a separate file for casualties.

"If studies are to be made of all casualties it may save hours and days of labor to have all the cases arranged alphabetically, by date, service or age as the request may indicate. If a list of all admissions is routinely made in the hospital or if a registry is kept of all cases, a check or asterisk indicating the casualty made in the margin of the entry will be a simple addition. When requests in the future ask you to indicate the number or list the admissions for a certain day or month the information will be at your fingertips. This procedure on your list of discharges or your discharge analysis will serve the same purpose for a request of discharges for a certain period.

"Entries in the diagnoses, manifestations, operation, treatment and physicians' indexes for the casualty patient can also be indicated by a check or colored pencil mark. This indication will prove a lifesaver

when you get the request for all casualty cases of gangrene, tetanus or amputations or for the cases that were treated with sulfathiazole or sulfadiazine.

"Your physicians will also appreciate your keeping the record of the number of casualty patients that they

cared for as well as the number of private patients they attended. A check in front of the casualty entry in your physicians' index will enable you to have this information available.

"Whether the indications listed for registries or admission and discharge

lists will be considered sufficient or whether we will be asked to keep an individual registry of all casualty cases treated on either the in-patient or out-patient services will depend on regulations set by the government and by the policy adopted by our hospital administration."

NURSING COSTS

EVERETT W. JONES

Administrator, Albany Hospital
Albany, N. Y.

WITH the nursing shortage becoming ever more acute and the cost of nursing service constantly mounting, a method whereby a hospital can reduce the amount of nursing service to patients by nearly 25 per cent and, in spite of increasing salaries and other costs, bring down the nursing cost by more than 10 per cent should be of general interest.

The foregoing results were accomplished at Albany Hospital, apparently without in any way lowering the quality of service to patients.

Our first step, taken back in 1935, was to make a time study of our nursing service based on the procedure outlined by Blanche Pfefferkorn and Marion Rottman in their study of nursing at Bellevue Hospital, New York City. We wanted to spot check for ourselves the figures compiled in Bellevue. We then worked out a daily report of nursing hours which has been in use since 1936. It appears herewith.

This daily report shows at a glance for each division of the hospital the exact total of bedside nursing hours per patient day and the total hours spent by all ward personnel per patient day.

These unit measurements are available for each nursing division (including the operating room, out-patient department, diet kitchen and general supervision). Totals are available covering all of the nursing units combined and for the general medical and surgical services (exclusive of communicable disease, obstetrics, pediatrics, psychiatric and tuberculosis services).

Our daily summary sheet also shows the total personnel of the nursing department on the pay roll and the number on vacation or sick leave.

In 1938, on the basis of several years' observation of these nursing

ratios, we drew up a tentative standard for nursing hours per patient per day for the year 1939. Again in December 1939, we checked on actual figures for eleven months against our tentative standards and found that 10 of the nursing locations had used less and six had used more hours than the standards. This is shown in table 1.

Table 1 also shows the median figures compiled by Miss Pfefferkorn and Charles A. Rovetta in 1938-1939 for 14 voluntary hospitals of from 90 to 900 beds. These figures appear on page 89 of "Administrative Cost Analysis for Nursing Service and Nursing Education." Exact comparisons could not always be made since the categories were not precisely the same. Also, apparently, Pfefferkorn and Rovetta did not in-

clude the time of aides, orderlies and floor clerks.

Our standards for 1940 (including the time of subsidiary workers) required more hours than the medians of the 14 hospitals in six nursing locations and less hours in five locations. The time of subsidiary workers having been omitted, our standards were below theirs in every location.

It seemed to us that we could make still further reductions in our nursing hours by additional intensive study. As a first step, we felt it would be desirable to check our experience with other hospitals. Accordingly, a letter with full explanation was sent on Jan. 11, 1940, to 48 selected hospitals. After one follow-up on June 20, 1940, and another on April 1, 1941, a total of 22 replies with more or less usable information was received.

The total hours of service per patient per twenty-four hours in report-

Table 1.—Tentative Standard for Nursing Hours per Patient per 24 Hour Day for 1940

Floors and Wards	General Staff, Practical and Student Nurses	Aides, Orderlies, Floor Clerks	Standards (Sum of Previous Columns)	Actual for 11 months of 1939	Pfefferkorn- Rovetta Survey
Communicable Disease ³ ...	4.6	1.5	6.10	5.49	4.7
Surgery—Men & Women ¹	3.0	1.5	4.50	5.04	5.4
Medicine—Men ²	2.75	1.5	4.25	4.38	3.2
Medicine—Women ²	2.9	1.5	4.40	3.91	3.2
Surgery—Men ²	2.75	1.5	4.25	4.13	3.2
Surgery—Women ²	2.75	1.5	4.25	4.02	3.2
Medicine and General Surgery—Women ¹	3.0	1.5	4.50	4.74	5.4
Medicine and Surgery—Men ¹	3.0	1.5	4.50	4.37	5.4
Surgery (Gyn.)—Women ¹	3.2	1.2	4.40	4.34	5.4
Obstetrics:					
Mothers and Del. ²	3.8	1.6	5.40	5.05	4.2-6.5
Babies (Nursery).....	2.1	0.4	2.50	2.44	2.3
Pediatrics ³	4.0	1.0	5.00	4.73	4.4
Psychiatry—Women ³	5.0	0.5	5.50	5.8	....
Psychiatry—Men ³	2.2	4.6	6.80	6.85	....
Tuberculosis—Women ³ ...	2.1	0.3	2.40	2.51	....
Tuberculosis—Men ²	1.3	0.75	2.05		....
Tuberculosis—Men and Women ²	1.3	0.35	1.65	1.63	....

¹Private and semiprivate patients.

²Service teaching wards.

³Private, semiprivate and ward patients.

Table 2.—Nursing Costs and Hours in 22 Hospitals, 1939-40

Size of Hospital Code No. and Location	Cost per Pt. Day	Wards, General	Priv. & S.P. Genl.	Obst. & Nurs- ery	Pediat- rics	Men- tal	T. B.	All
More Than 500 Beds								
A—Chicago.....	\$3.15	4.7	7.8	...	5.9	5.7	...	...
B—New York City.....	2.85	4.6	5.5	...	7.3	...	...	...
C—New York City.....	2.76	4.0 ¹	6.4	4.3	5.1	...	...	...
D—Boston.....	2.60	4.2	5.6	8.9	6.2	9.0	...	...
E—Upstate New York.....	2.40	4.4	6.4	3.5	5.0	...	...	...
F—Canada.....	2.34	...	...	...	...	...	...	...
G—Albany Hospital.....	2.34	4.3	4.5	7.6	5.0	6.2	2.2	...
H—New York City.....	...	2.8	6.4	5.8	3.0	...	2.2	...
I—New York City.....	...	...	...	...	...	...	...	3.6
J—Michigan ².....	...	2.4	...	5.5	...	3.5	1.4	...
Average.....	\$2.63	4.1	6.3	6.0	5.5	6.1	2.2	...
From 300 to 500 Beds, Inclusive								
K—Chicago.....	\$2.32	...	...	...	...	...	...	5.6
L—Cleveland.....	2.24	2.9	4.0	...	...	...	...	...
M—Upstate New York.....	2.15	4.6	4.9	6.5	3.9	...	...	...
N—Missouri.....	2.05	...	...	...	...	...	...	...
O—Upstate New York.....	1.98	...	...	...	...	...	...	3.8
P—Pennsylvania.....	...	...	...	...	...	...	...	4.4
Q—Minnesota.....	...	3.5	4.8	5.2	...	...	...	...
Average.....	\$2.15	3.7	4.6	5.8	...	...	...	4.6
From 150 to 299 Beds, Inclusive								
R—New York City.....	\$2.31	...	...	...	...	...	...	3.1
S—Upstate New York.....	2.20	...	...	...	...	...	...	...
T—Upstate New York.....	1.96	...	...	...	...	...	...	4.1
U—Upstate New York.....	1.76	3.0	2.9	5.3	2.7	...	...	...
V—New Jersey.....	...	3.5	4.3	...	...	...	...	...
W—Upstate New York.....	...	...	...	...	...	...	...	3.7
Average.....	\$2.06	3.3	3.6	...	...	...	...	3.6

¹Includes semiprivate.
²Includes nursing hours only.

ing hospitals is shown in table 2. It should be noted that the figures include service by nurses' aides and orderlies as well as by graduate staff nurses and student nurses. Table 2 shows the nursing cost per patient day including salaries and the value of all maintenance of employes engaged in nursing service and nursing education.

The larger hospitals among those reporting, apparently, spend more for their nursing service than the

smaller institutions spend. This is true in spite of the fact that the larger hospitals provide more service by nurses' aides and orderlies than do those of less than 500 beds. The arithmetical averages on the cost of nursing service per patient day were \$2.63 for the hospitals of more than 500 beds, \$2.15 for those of from 300 to 500 beds and \$2.06 for hospitals of from 150 to 299 beds.

Our cost at Albany of \$2.34 was the lowest for any of the hospitals

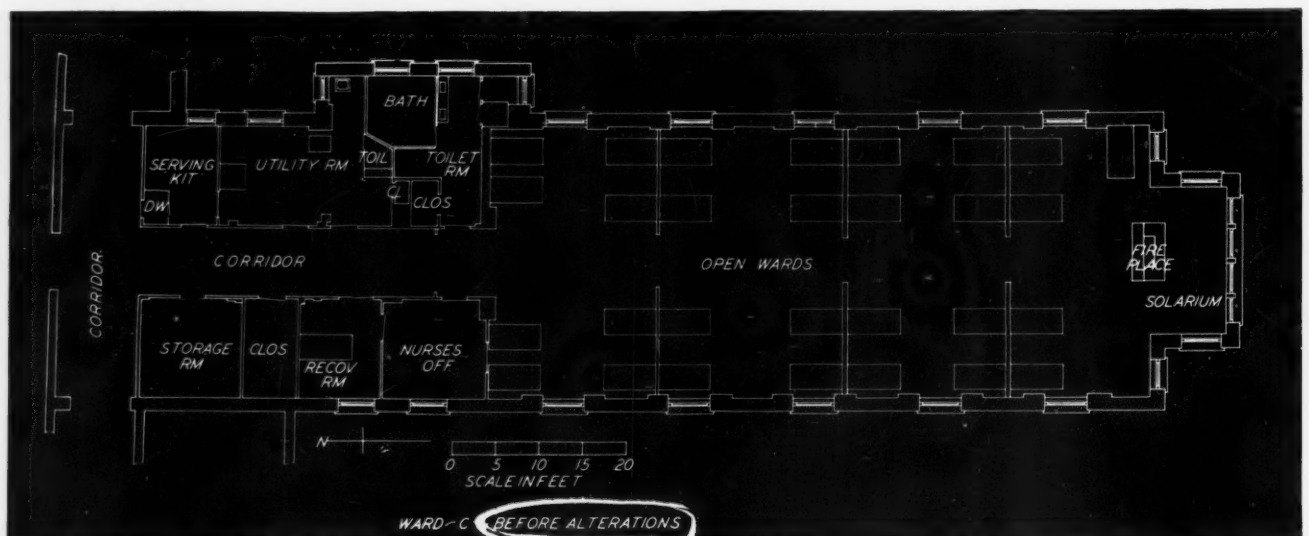
of more than 500 beds but none of the hospitals of less than 500 beds spent this much. Naturally, we asked why the hospitals of more than 500 beds and particularly our own should have nursing costs that exceeded those of the smaller institutions. The answer was quickly found: they gave more hours of service.

In the general wards, for example, the larger hospitals that gave figures had an average of 4.1 hours per patient, the hospitals of middle size (300 to 500 beds) gave 3.7 hours and the hospitals in the smallest group gave 3.3 hours. For private and semi-private patients the figures were respectively: 6.3 hours, 4.6 hours and 3.6 hours.

But is it necessary to give as much service as we are giving, particularly in view of the fact that other hospitals of equally fine reputation seem to be able to get along with fewer hours?

The director of nursing service, working with various nursing, medical staff and administrative staff committees, has worked unceasingly for improved nursing care for patients, operating economies through reduced personnel and better working conditions for employes.

The success of these efforts is shown in the fact that the over-all nursing hours per patient per day for private, semiprivate and ward patients in general medicine and surgery have been reduced from 4.99 in 1939 to 3.80 in the first three months of 1942. The nursing wage cost per patient day was \$2.34 in the first period and \$2.04 in 1942 in spite of wage increases of approximately

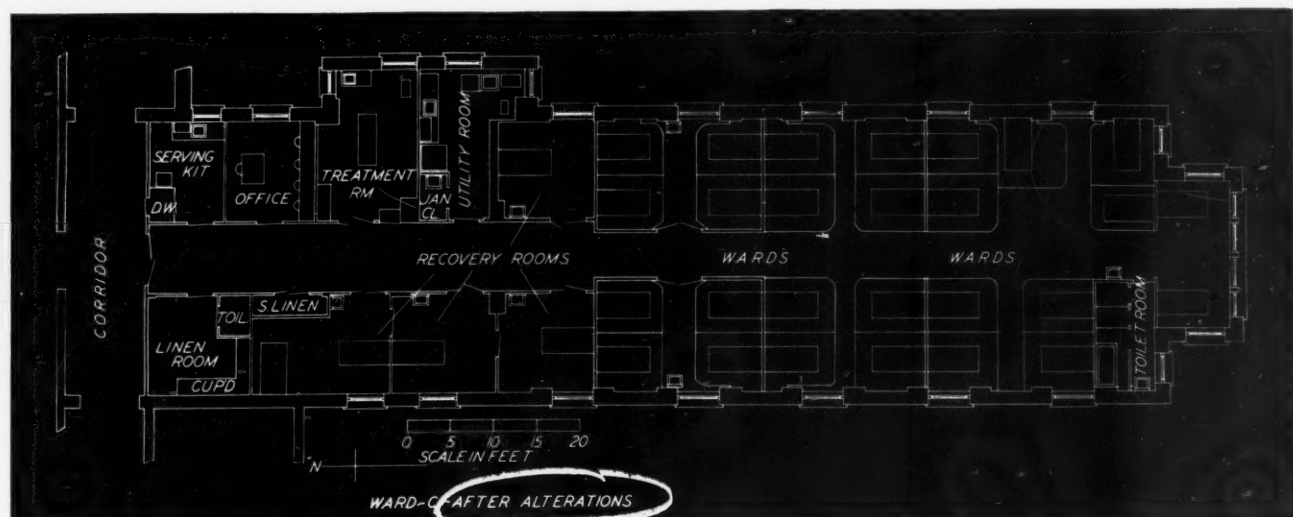


Date April 15, 1942	2	3	4	5M and Del.	5B	6	A1	A2	B1	B2	C1	C2	MM1	MM2	HM	TBS	Total	OR	OPD	DK	Control	
Census																						
Census as of 12:01 a.m. this date...	54	47	52	30	30	27	18	28	33	32	30	30	16	18	56	63	564	
Percentage of occupancy.....	106	92	102	79	53	55	60	90	100	97	100	100	94	106	104	95	88	
Gain or loss in census over this date last year.....	4	2	4	12	14	1	1	2	4	5	2	2	5	2	3	3	
Staff Load																						
Total patient hours for this day....	1296	1128	1248	720	720	648	432	672	792	768	720	720	384	432	1344	1512	13536	
Special nurse hours for this day....	252	214	122	5½	2	46	23	23	23	23	733½	
Patients on staff care.....	43	38	47	30	30	25	17	27	33	32	29	29	16	18	56	63	533	
Ward Supervisory Hours																						
Head nurses and those who relieve them.....	26	26	26	26	14	17	14	17	17	17	17	17	14	14	17	14	293	16	
Supervisory hours per pt. per day...	.48	.55	.50	.87	.47	.63	.78	.61	.52	.53	.57	.57	.88	.78	.30	.22	.52	General Services.....	53	
Bedside Nursing Hours																						
General staff nurses incl. hourly nurses	83½	79¾	85	69½	54½	25½	37½	53½	47¾	57½	57¾	51¾	53	18	50½	28½	853½	128	52½	13	3½
Senior student nurses.....	6½	11	13	7	30	12½	80	36
Junior student nurses.....	13	35½	13	57½	119	42½	10	17	5½
Sophomore student nurses.....	34	22	13	20½	18½	140½
Postgraduate student nurses.....	4	2	14	6	4½	30½	5½	10½	4	2
Practical nurses.....	31½	34	36½	22	17	8½	8½	51	51	268½	8½
Total bedside hours.....	128	113¾	125½	107	67½	119	77½	75	84¾	90	91¼	85¾	83	30½	134	79½	1492	184½	109	17	17	11
Bedside hours per patient per day	3.0	3.0	2.7	3.6	2.3	4.8	4.6	2.8	2.6	2.8	3.1	3.0	5.2	1.7	2.4	1.3	2.80	General Services.....	2.86
Supplementary Bedside Hours																						
Floor clerks and aides.....	58½	33½	41½	33½	25½	30	17	33	8½	21	8½	18½	17	8½	354½	27½	49	3½	
Orderlies and attendants.....	20	9	10¼	20	28	50½	23	18	178¼	36	9	16
Total hours of supplementary workers.....	58½	53½	41½	33½	25½	30	26	43¼	28½	21	36½	18½	17	59	23	18	533¼	63½	9	65	3½
Supplementary hours per pt. day....	1.1	1.1	.80	1.1	.85	1.1	1.4	1.5	.86	.66	1.2	.62	1.1	3.3	.41	.29	.95	General Services.....98
Total bedside hours per pt. per day	4.1	4.1	3.5	4.7	3.2	5.9	6.0	4.3	3.5	3.5	4.3	3.6	6.3	5.0	2.8	1.6	3.75	General Services.....	3.84
Total hours applied by all ward personnel.....	4.6	4.7	4.0	5.6	3.7	6.5	6.8	4.9	4.0	4.0	4.9	4.2	7.2	5.8	3.1	1.8	4.27	General Services.....	4.37
Nursing Department Personnel																						
																	Special Nurses					
	Admr. and Super.	H. N																				

I. Making job, motion and routine analyses on wards in an effort to determine what physical changes might reduce nurses' travel.

The layout was planned with the cooperation of the director of nursing service, supervisor of surgical wards, head nurses and selected graduate staff nurses. Models were

At one time we thought that 3.5 hours of graduate and student service plus 1.5 hours of service from orderlies and aides, or a total of 5 hours per patient day, was necessary. After the physical changes were made we set the standard at 4.25



hours and are now operating these surgical teaching wards with as low as 3.2 hours and a maximum of 3.8 hours for all nursing personnel without much apparent sacrifice of nursing standards.

2. Analyzing all nursing procedures by a nursing procedure committee and by our professional advisory committee (see *The Modern Hospital*, November 1941, p. 6). This group of nurses and physicians has done a splendid job in eliminating frills and unnecessary things from our standard procedures.

A typical example of this is the "Preparation of a Unit for a Post-operative Patient." The old procedure required a full set of linen for all cases and a treatment blanket for one type of bed. The new method uses less linen and the treatment blanket is eliminated. Simpler bed preparation is provided for minor surgical cases and specific requirements are laid down for certain special kinds of cases occurring frequently in our hospital (head cases, gynecologic operations, thyroidectomies, genito-urinary operations and chest surgery).

3. Enlarging of the general messenger service of the hospital to relieve nurses, aides and orderlies of many delivery errands. For example, a messenger now collects orders for diet changes and extra nourishments. The ward personnel is instructed not to leave the ward except in extreme emergencies.

4. Reviewing doctors' orders each day to check upon the possibility of discontinuing time-consuming treatments as soon as possible.

5. Discontinuing the use of nurses, aides or orderlies to take ambulatory patients to the x-ray, physical therapy and other departments. Special duty nurses are made solely responsible for transporting their own patients to operating rooms, x-ray and other departments.

6. Discouraging in all possible ways doctors' rounds, examinations and dressings at mealtime and during periods of routine morning and evening care.

7. Developing a folder containing suggestions for the patient to follow in saving the nurses' time. This explains the daily routine of

patient care; as a result, patients call the nurses less often.

8. Preparing operative schedules carefully to avoid excessive numbers of major operations on any one day; this helps to reduce peaks of postoperative care on the wards.

9. Drastically reducing the total visiting hours and number of visitors per patient in wards and semiprivate rooms. The use of visitors' passes is a great help. Grey Ladies of the Red Cross pass out visiting cards and patrol the wards and semiprivate rooms to relieve the nurses of supervision of visitors. Ward visitors are restricted to two to a patient at one time and hours have been reduced from two hours each afternoon and evening to one hour only on Monday, Wednesday and Friday evenings and Tuesday, Thursday, Saturday and Sunday afternoons.

10. Using a central supply room with aides under a graduate nurse.

11. Providing enough housekeeping maids to do the housekeeping work and enough nursing aides to perform the dozens of nonprofessional duties that nurses have done in the past.

12. Taking the temperature, pulse and respiration only twice a day unless the temperature is elevated to 100° F. or the physician requests more frequent readings. If the temperature is taken four or six times a day and it drops to 99.6° F. for twenty-four hours, the twice a day routine may be recommended. Unless the physician writes a definite order, the head nurse uses her own judgment in placing patients on the routine or the four hour schedule.

13. Appointing a standards committee to work out specifications for all materials, supplies and equipment called for by the nursing procedure and professional advisory committees.

14. Seeking proper cooperation between the operating room and nursing units so that the latter will know when a patient is to go to the operating room and approximately when he is to return.

15. Using a covered jar for solutions ordered in a hot pack

procedure which can be kept in a steamer, thus eliminating separate heating of the sterile solution.

16. Installing a convenient rod on which to hang the patient's clothes before they are taken to the clothes room.

17. Eliminating elaborate ward perineal preoperative preparations on gynecologic cases because the work is done again in the operating room.

18. Reducing the nurses' notes as soon as patient has passed the acute stage, eliminating all remarks except those relating to treatments, medications or fluids.

19. Arranging the procedure manual logically and cross indexing the procedure manual carefully to save time. Using both sides of the paper to save paper and decrease size of manual.

20. Studying carefully the supply and distribution of wheel chairs and stretchers to save time in getting them when needed.

21. Using volunteers to escort discharged patients from floors to the cashier's cage during peak periods.

In attempting to determine where and how economies can be made, personal visits to the nursing locations and to a cross section of patients were made by the hospital administrator, assistant administrator, director and assistant directors of nursing service, supervisors and head nurses. These are essential if we are to find our faults, correct weaknesses and discover new and less costly methods to improve service and still make economies. The ideas and facts collected were pooled in group meetings.

A careful analysis of patients' comments from questionnaires (which 75 per cent of the private and semiprivate patients filled out in 1939 and, again, in 1941), coupled with personal talks with many patients, has convinced me that the lesser hours per patient day now in force has not lowered the quality of our service. Whether we can further decrease hours or, in view of the ever-increasing demands of scientific medicine, even hold the present level without overtaxing the physical and mental endurance of our nursing personnel remains to be seen.



To forestall recurrences of rheumatic fever, the Franciscan Missionaries of Mary and the medical staff carry on a continuous fight. How well they succeed is shown by the statistics: readmissions are only 5 per cent.

Care for Cardiacs

RAYMOND P. SLOAN

"**B**UT where do they go from here?" a woman visitor to the cardiac clinic for children in Kings County Hospital, Brooklyn, N. Y., inquired in the early winter of 1936 as she watched a group of pale youngsters passing out through the door in the custody of their troubled parents.

Dr. Leo M. Taran, chief of the clinic, and his associates had asked that same question of themselves many times but had found no satisfactory answer. The little patients came and went until they came no more. A great majority never went anywhere again, the doctors were convinced, although they could be sure of nothing.

Between 20,000 and 30,000 children, representing 2 per cent of the entire school population of Greater New York, are sufferers from rheumatic disease, the visitor was told. They are medical and social outcasts; economically helpless, too,

many of them. No suitable provision for their home care is possible; general hospitals can accommodate them only during the acute stages of the baffling disease and convalescent care is inadequate.

Only 300 beds in institutions in Greater New York are devoted exclusively to the care of rheumatic heart disease patients, according to Dr. O. F. Hedley, surgeon of the U. S. Public Health Service. The total for the entire country is less than a thousand.

This interpretation of the acute problem of treating children with heart disease aroused the interest of the visitor to the Kings County Clinic and, in turn, was brought to the attention of other public-spirited women of the community who determined to find the answer. Its challenge appealed also to the Franciscan Missionaries of Mary, who at the time had a summer camp for poor children on Long Island.

At the beginning of 1937 a small committee of the women's auxiliary of the Kings County Hospital, together with Doctor Taran, in conference with the Franciscan Missionaries of Mary, founded the St. Francis Sanatorium for Cardiac Children. So it happened that in February 1937, 12 small girls suffering from rheumatic fever arrived in Roslyn on the property given to the courageous and enthusiastic group of Sisters by the late Carlos Munson.

It started as a sanitarium, but within five years it has developed into one of the largest institutions in the country devoted to the treatment and study of rheumatic fever. Its original home was a stable, but what it lacked in equipment the Sisters made up in enthusiasm and good will.

Today six brick buildings, five of them designed for inactive cases and the sixth a completely equipped hospital, provide care for 150 children. The staff now comprises, in addition to the medical director, a resident physician, a visiting staff of eight, a medical advisory board of eleven, four visiting dentists, a laboratory director, four laboratory technicians and eight graduate nurses.

Two types of cases are treated at St. Francis'. First there are those children who, having had rheumatic fever and having suffered some cardiac damage, must have their resistance built up to preclude any recurrence of the rheumatic episode. Authorities agree that the prevention of rheumatic occurrence is the best means of combating progressive cardiac disability. Second are the children who, having sustained considerable heart damage before being admitted to the sanitarium, require hospital care. Probably 20 per cent who have been declared hopeless are not hopeless and about one fifth can be returned to modified normal life. Periods of treatment run from eight



months to three to five years, the average stay being nine or ten months.

The sanitarium is completely hidden from the public road by a wooded hill, only the front of the convent being discernible to the visitor who approaches up the long driveway. His surprise is the more complete, therefore, upon facing a circle of friendly looking, low buildings, connected by underground and overground passages and placed at right angles to provide abundant sun and air. Around these cottages the driveway broadens into a large open court, with signs indicating the hospital building.

Six families of 25 children each constitute St. Francis' design for living. Rheumatic fever is a sociologic as well as a medical problem and anything that denotes hospitalization or institutionalism is to be avoided. Even middy blouses are discarded in favor of different patterned suits and dresses. The aim is to minimize the child's disabilities and to permit him to live as normal a life as possible.

St. Francis Sanatorium approximates a modern boarding school regimen, minus its disciplinary measures. It is a mistake to assume that every child with rheumatic heart disease is a psychiatric problem. Doctor Hedley in *Public Health Reports* for 1941 states specifically: "It is doubtful whether the percentage is any greater than in the general population. On the basis of a number of years of practical experience, the writer has been impressed with the infrequency of behavior problems."

A circle of six low friendly looking buildings constitutes this plant.

Doctor Hedley's experience parallels that of Doctor Taran and the Mother Superior at St. Francis'. There simply isn't any behavior problem, they agree.

Five of the cottages are practically identical, each having a spacious dormitory at either end, a dining room equipped with small round tables, a schoolroom, recreation room, kitchenette, utility room and its own playground.

One of these units serves as isolation quarters to which new members of the family are assigned for three weeks. Here the upper floor becomes the permanent home of boys, of whom there are 25 ranging in age from 6 to 9. The girls may stay until they are 16.

A Sister is in charge of each home with an assistant and a maid. In such harmonious and attractive surroundings, the active phases of the disease are treated.

The one story and basement hospital building provides two single rooms, one double room, one room for three and two wards of 10 beds each. To this unit are assigned those children suffering from acute rheumatic fever.

Two large charts on the wall of the administrator's office reveal by varied colored pins the complete story of the entire family. Hazel Smith, for example, while an active patient has progressed to the point that she need be in bed only part of

the time, but Edwin Johnston is still in the acute phase of the disease. Frieda Kronfeld is now classified as inactive and enjoys practically a normal life.

The broad corridors open onto rooms flooded with sunshine from which come chuckles and squeals of delight. It is story hour.

Earlier in the day there have been visits to the cardiograph room, which is fully equipped for metabolisms and stethograms, and to the x-ray and fluoroscopy room. A three bedded oxygen room constitutes an attractive little suite by itself with the jovial figure of Pinocchio at the entrance to extend a welcome and colorful wall panels to supply diversion. A treatment room for special procedures, utility rooms, admitting office for active cases, and business offices complete the main floor.

The basement contains further treatment rooms including a solarium where 10 children at a time may receive ultraviolet rays, also a busy dentist's office. Here, too, is where the research work is conducted. Two laboratories for chemistry and bacteriology provide not only for routine procedures but for research in the field of rheumatism with a third room serving as preparation room. A conference room for the visiting staff and a faculty room for the school teachers, of which there are six, complete the pattern.

Starting from nothing the laboratories now boast four especially trained technicians and a full-time bacteriologist. The Sisters originally had little knowledge of such proce-

dures other than that gained in their training course, but they were willing to learn. In addition to the time Doctor Taran spent with them, he brought with him from the city professional friends who aided them. The education thus acquired in bacteriology and blood chemistry, the Sisters have passed along to others who serve as assistants.

The nursing is done by eight graduates and four undergraduates, thus ensuring one graduate to every six hospital patients. Graduates are not required in the buildings for inactive patients.

Whether the child is classified as active or inactive, the admitting procedure is the same except that if admitted directly from a hospital he need not be isolated. The only requirement is a history of rheumatic disease with medical and social records submitted one week prior to admission. Also, if the child has had a positive tuberculin test in the hospital, chest plates are required to assure no lung tuberculosis.

The routine work-up is as follows: examination by the resident physician, cardiograms, fluoroscopy, metabolism, weighing, blood pressure reading and the usual blood tests. These are accomplished within the first seventy-two hours. Then comes the final diagnosis with individual treatments as needed.

The sociologic development of the child at St. Francis' is of equal importance with his medical progress and is the subject of constant study. This accounts for the social pattern in which the family group is divided into six units, each living under its own roof entirely independent of others. Only on such occasions as Sunday afternoons, when some friend provides motion picture entertainment in the large auditorium or when matters involving the interest of the entire community are to be taken up, does the entire family assemble.

The daily schedule of the inactive patient differs little from that of the average child except for regular periods of rest and physical check-ups. As in normal life, he enjoys companionship with a small group of children during study and recreation hours. School occupies a major portion of each morning, followed by periods of supervised games and occupational training.



The Sisters had to acquire laboratory technics so they set about it.

To make up for the pleasures of the old swimming hole, two wading pools are provided on the sanitarium grounds. Disabilities are minimized at St. Francis'.

Two days each month are observed as Parents' Day. Parents of one half of the children visit on the first Sunday in the month and the parents of the others on the third Sunday. In inclement weather visiting takes place in the auditorium; during the summer months groups gather on the green lawns and under the shade trees. Other visiting is restricted to the hospital building where parents are permitted to see acutely ill children more frequently. "No child visitors anywhere" is the rule at all times.

The physical and social needs of this family of 150 are vigilantly supervised by the group of 32 Sisters, who also administer the affairs of the sanitarium and provide for its support. Except for the sum of \$1.40 per child received from the city, all expenses are met by individual contributions.

Through the gift of one benefactor the Franciscan Missionaries own the beautiful property of 15 acres on which they grow fruits and vegetables which they preserve and store for winter use. Two of the Sisters are thus engaged during most of the summer season.

There comes the day when the doctors are ready to reassign the child to his own home environment with necessary modifications. The chart

hanging on the wall of the business office reveals a satisfactory record. This fact is manifest as well in the clear eyes and skin of the patient, his strong young body and his new look of confidence and hope.

Will he come back? Recurrences of the disease are comparatively rare after convalescence. The record at St. Francis Sanatorium shows that readmittances are only 5 per cent.

On his own again the patient's care becomes the responsibility of his family. Efforts are made to follow through on each child with the social workers of the 40 hospitals that have referred children to St. Francis', and also by mail. In the next few weeks St. Francis Sanatorium plans to employ its own social workers to help in post-convalescent supervision.

Extensive research projects are now planned by Doctor Taran and his associates in order that more definite knowledge may be gained about this disease that threatens the lives of more than a million in the United States today. It is hoped that more research facilities will become available at this institution.

In the meanwhile the Franciscan Missionaries of Mary with Doctor Taran and his associates at St. Francis Sanatorium in Roslyn are fighting persistently to forestall recurrence of rheumatic fever through accurate diagnosis, carefully prescribed medical treatment and a social environment that will build strong bodies and make sound citizens.

THREE FORMS

HELEN M. YERGER

EVERY new idea introduced into the business or service realm produces adjustments in ordinary procedures. So it was with hospital insurance plans.

Previous to the birth of this idea, most hospitals kept systematic records. These consisted mainly of the admission slip, ledger sheet and the medical record chart with all of the various forms necessary to make the chart complete. The items on these various forms varied with each institution.

With the systematizing of our hospital service plan, hospitals have been called upon to render to the service plan a copy in miniature of the admission slip, a complete ledger sheet showing all the credits allowed by the plan, the day of discharge, diagnosis, and the amount to be paid the hospital by the plan.

It is true that most plans furnish the forms that they require to be filled in. At the beginning of the Rochester Service Corporation, we at the Park Avenue Hospital followed the usual course of procedure, using the forms sent us by the plan. The number of hospital insurance patients was small and the extra work involved in completing these forms was not noticed.

With the growth of the plan the number of patients increased until our business office was found deluged with detailed clerical work. The question of employing another clerk to care for this work was finally agreed upon. An added employee required another desk and chair, as well as desk space. The desk and chair might have been purchased but the desk space was not to be had without performing a major carpentry job.

A—Quadruple Admission Notice

In analyzing the situation, we noted the number of times facts concerning hospital insurance patients were not only duplicated but triplicated by the office staff. It was this analysis that produced the idea of printing a quadruple admission notice (Exhibit A). Sheets 1 and 2 are identical, the form requested by the service plan. Sheets 3 and 4 are also

identical but they are extended and contain the further information that we require of the patient at the hospital. Since 53 per cent of our patients are hospital insurance cases, you can appreciate the saving in time and effort of having this quadruple form.

When a patient is admitted, one of the first questions that is asked is whether he is a member of the service plan. If the patient is not, the two top sheets are torn off, leaving the other sheets intact for the hospital record.

B—Triplicate Ledger Sheet

One idea generally produces another, as in the case of the triplicate ledger sheet (Exhibit B). This triplicated sheet consists of a top sheet, the permanent ledger record; the second sheet, the final statement for the patient, lacking the data at the bottom of sheet 1; the third sheet, a duplicate of sheet 1, it being the copy of the patient's account that is sent to the service plan.

This triplicate ledger sheet has been a lifesaver in our office. It was difficult at the beginning for anyone not conversant with the credits allowed by the hospital service plan to give to the patient, upon request, the exact balance due. It was left to the bookkeeper to adjust and often the hospital suffered through lapse of payment. With this form, the balance is always in evidence and the credits are allowed as well. In this way the staff member answering questions concerning the account is always able to give accurate information.

Then, too, the section ruled for "cash," "hospital insurance" and "adjustment" serves its purpose. The space denoted by "cash" indicates the amount the patient is to pay. The "hospital insurance" space is for the amount to be received from the service plan, while the space allotted to "adjustments" is the difference, whether debit or credit, between the total amount of the hospital bill and

the totals of cash that the patient pays and the amount paid by the service plan.

When the amount of adjustment is a debit, it is shown in black. A credit adjustment is listed in red.

Let it be said here that before these forms were given out to the printer full approval was received by the Rochester Hospital Service Corporation. Not only do they serve their purpose in eliminating duplicate effort by the office staff, but admission slips and statements are complete with the entry or the discharge of every hospital insurance patient. The service plan is able to receive the bills just as soon as the patient leaves the hospital. The plan does not have to wait for an employee to type duplicate bills.

The credit allowances afforded by the service plan increased the usage of various services. There were times when we found ourselves with additional charges for the patient's bill, after the patient had been discharged and the account paid. To send an additional bill in many instances has been found to produce poor public relations.

C—Special Charge Slip

The special charge slip (Exhibit C) was conceived to overcome this difficulty. It embraces all of the divisions of service with a space left for any extraordinary charge. This form consists of four sheets: the first is white; the second is pink; the third is red, and the fourth is plain tissue. The last named remains in the folder for the supervisor's permanent record. This special charge slip is like a retail salesbook; instead of producing duplicate copies, it is set up to produce four copies.

When a charge is to be made to the patient the supervisor of the division is responsible. The form completed is divided as follows: the white sheet goes to the business office to be filed alphabetically; the pink form and the red inked form are sent to the division that is to

That Saved a Salary

Assistant Administrator, Park Avenue Hospital, Rochester, N. Y.

render the service. When the service is rendered the division then inserts the amount in the lower right hand corner and sends to the business office the pink sheet, retaining the one printed in red for the division's record.

The reason for sending the white form to the business office in advance of rendering the service is to warn the office that other charges are to come, in case the patient is

discharged before the division sends the amount to the office.

The charges are then posted to the patient's ledger sheet each day and filed in an envelope that shows a recapitulation of special charges.

In the process of outlining this special charge slip the supervisors were approached with trepidation. The amount of detail requested of the supervisor was, it was thought, a damper on its acceptance. After

meeting with them for two or three sessions much to our surprise we found them most cooperative and with their suggestions changes were made until the final effect was achieved. At first they used it slowly, but with daily usage they became accustomed to the change. They now enjoy having their permanent record to show.

While there was extra expense involved in printing these forms, they not only have saved the expense of another office employe but have increased office efficiency greatly.

ADMISSION NOTICE

To: Rochester Hospital Service Corporation
820 Reynolds Arcade, Rochester, New York

You are hereby notified that on 7-1-41 Name Mr. John Doe
(Date) (Name of Patient)

was admitted to PARK AVENUE Hospital under Contract No. 2000
for treatment at the request of Doctor Smith
and was assigned to private accommodations at \$7.00
(Mark Semi or Private) (Rate)

Is patient Subscriber or Dependent Sub Age 45 Date of Birth 8-1-96
(Mark S or D)

Is there any possibility of this being a compensation case? No
(Answer Yes or No)

Subscriber's Name John Doe
Address 123 Brown Street
Employed Jones & Company
Admitting Diagnosis Appendicitis

Check Type of Case: Accident ☐ Emergency ☐ Non-Emergency ☒

Date 7-1-41 By JL (Admitting Officer)

This patient is eligible for hospital insurance and entitled to _____ days under the terms of his Contract.

Claim No. _____ By _____

ROCHESTER HOSPITAL SERVICE CORP.

Admission Number 42000 Re-entry no Sex male
Birthplace Rochester Occupation mechanic Time 4:40 P.M.
Religion Protestant Church Asbury

Name and Address of Relative or Friend for Notification: Wife -- Sarah
same address
Telephone No. Monroe 1234

Responsible Party: Self and Hospital Insurance
Employed: Jones & Company

Remarks _____

SPECIAL CHARGE PARK AVENUE HOSPITAL
For Item Checked Above — Described Below

PATIENT'S NAME Smith SEX M DATE 7-1-41 AGE 45 ROOM NO. 212

SPECIAL NURSES: Furnished 3 Omitted 3

DOCTOR: Smith Surg. Description of Case Appendectomy Time Ordered _____ Time To Be Given _____

Specimen: Major 15.00
Gas Ind 10.00

Supervisor V. Welch Rec'd. By J.L. STAT. ROUTINE TIME

LEDGER PARK AVENUE HOSPITAL
ROCHESTER, N. Y.

NAME Mr. John Doe
ADDRESS 123 Brown Street

TIME 4:40 P.M. NO. 42000 RM 212 \$ 7.00

DATE	DESC.	CHARGE	DATE	DESC.	CREDIT	BALANCE
JUL 1	LBTRY	3.00	HSP INSR		3.00	.00 BAL
JUL 2	OPR. RM	15.00	HSP INSR		15.00	.00 BAL
JUL 2	ANES	10.00	HSP INSR		10.00	.00 BAL
JUL 2	MEDSR	2.50	HSP INSR		2.50	.00 BAL
JUL 1	BRD-RM					
JUL 8	BRD-RM	49.00	HSP INSR		31.50	17.50 BAL
JUL 9	EXG	10.00	HSP INSR		10.00	17.50 BAL
JUL 10	XRY	1.50				32.50 BAL
JUL 11	PEDSR	1.50	HSP INSR		1.50	32.50 BAL
JUL 8	BRD-RM					
JUL 15	BRD-RM	49.00	HSP INSR		31.50	50.00 BAL
JUL 15	CSH				50.00	.00 BAL
FINAL DIAGNOSIS						
CASH	50.00		JUL 15	CSH	50.00	.00 BAL
H. INS.	91.00		AUG 15	CSH	91.00	.00 BAL
ADJ.	14.00		AUG 15	ADJ.	14.00	.00 BAL

PATIENT'S NAME Mr. John Doe AGE 45 SEX M MARITAL STATUS M

CONTRACT NO. 2000

Smith X MEDICAL—SURGICAL—MATERNITY

1, 1941 July 15, 1941 Improved

DATE DISCHARGED _____ CONDITION ON DISCHARGE _____

ITAL STAY 15 DAYS COVERAGE 15 DAYS @ 6.50 \$ 91.00

ILL 7-15-41

USED BY (PLEASE SIGN) _____ TITLE _____ DATE _____

Jones & Company
Mechanic

28 DAYS WILL PAY @ \$2.50 PER DAY FOR ROOM

PER DAY _____

Park Avenue Hospital's three new forms were designed to reduce the amount of clerical labor involved in handling Blue Cross patients.

Don't Be an Individualist

EMIL FRANKEL

HOSPITAL administrators in New Jersey have long known the desirability of uniform accounting and statistical methods. The frequency with which this subject has appeared on convention programs and the interest shown in the work of the committee on accounting and statistics* of the New Jersey Hospital Association are evidence of this.

Variance of opinion concerning details has been one barrier in the past. Another has been the exceptionally fine accounting systems in certain hospitals, which administrators and boards have been reluctant to change in favor of an untried new system.

In developing a manual on "Uniform Accounts and Statistics in New Jersey General Hospitals," which has been officially approved by the New Jersey Hospital Association, the committee has tried to be realistic about these difficulties.

The proposed system is flexible, while retaining comparability with smaller institutions in which such usages have been analyzed, and it is believed that the new system can be introduced into any hospital with only unimportant changes and without destroying the continuity in the statistical and accounting statements that administrators have found useful in the past.

Scheme of Classifying Accounts

The general scheme by which accounts are classified in the uniform chart of accounts is outlined in the third column, where the chief items charged under operating and nonoperating expenses and the various types of income accounts are tabulated.

The uniform chart of accounts also provides for the maintenance of asset accounts and liability and reserve accounts, by which the capital position of the hospital can be continuously observed and analyzed.

*This committee is composed of the following members: LeRoi A. Ayer, I. E. Behrman, George H. Buck, William J. Donnelly, Frank B. Gail, Emil Frankel, Ralph J. Glover, Ferdinand Kaiser, E. J. Krahenbuhl, L. Kranztohr, Charles R. Lloyd, W. Crane Lyon, W. Malcolm MacLeod, Alexander M. MacNicol, G. W. Sinnott and H. McC. Wortman.

On the basis of the classification of financial accounts of the manual it will be possible to present a comprehensive periodic report—monthly, quarterly, annually—that could be used (a) for comparing the individual hospital's finances between different services and periods and (b) for comparing the individual hospital's finances with those of other hospitals or with the finances of the hospital group as a whole.

The periodic financial report form which accompanies the manual is divided into: Schedule A, giving a statement of income according to the various patient classifications; Schedule B, giving a statement of expense by departmental classifications; supplementary information regarding the individual hospital's method of accounting.

These periodic reports have been planned as a summary and recapitulation of hospital accounts maintained on an accrual basis. They should serve equally well in hospitals whose accounts are set up differently. As a safeguard against attempts to compare data compiled on the accrual basis and data otherwise compiled, the report form calls for a statement as to the basis on which accounts are kept.

The committee has recommended that the hospitals adopt this form for recording their income and expenses and use it in their own reports, substituting this form of report for any similar report which they may now compile.

The committee further recommended that this report form be used for an annual report to be submitted to the New Jersey State Department of Institutions and Agencies at the close of the calendar year. From the figures of the annual report supplemented by the statistics derived from the monthly hospital service summary reports rendered to the department, it will be possible to work out significant cost and income figures.

Since 1929 the figures resulting from the monthly hospital statistics

reporting system have been utilized in many ways by both the individual cooperating hospital and the Department of Institutions and Agencies in depicting the work and financial operations of the general hospitals in New Jersey.

The success of this undertaking lies in the fact that the items included in the schedule for monthly

EXPENSE ACCOUNTS

I—Operating Expense Accounts

1. Professional care of patients, general
2. Professional care of patients, special
3. Out-patient department
4. Dietary department
5. Household
6. Plant operation and maintenance
7. Administration
8. Religious services
9. Provision for depreciation of equipment
10. Department of education and research

II—Nonoperating Expense Accounts

1. Interest
2. Pension payments
3. General expenses
4. Provision for depreciation of hospital buildings
5. Expenses of nonhospital services

INCOME ACCOUNTS

III—Gross Earnings From Hospital Services

1. Board and room
2. Professional services
3. Out-patient department
4. Emergency service
5. Other income

IV—Deductions From Gross Earnings

1. Courtesy allowances
2. Charity allowances
3. Hospital plan allowances
4. Bad debt allowances

V—Nonoperating Income Accounts

1. Income from governments
2. Voluntary contributions
3. Endowment income
4. Miscellaneous income from nonhospital services

ASSET AND LIABILITY ACCOUNTS

VI—Assets

1. Operating assets
2. Unrestricted legacies fund
3. Endowment fund assets
4. Plant assets

VII—Liabilities and Reserves

1. Operating liabilities and reserves
2. Unrestricted legacies fund liabilities and reserves
3. Endowment fund liabilities and reserves
4. Plant liabilities and reserves

in your accounting system

Director, Division of Statistics and Research
New Jersey Department of Institutions and Agencies, Trenton

reporting were those that any hospital should be able to furnish without great labor and yet, when compiled, would have the data essential for comparison. In order to make these hospital statistics of the greatest practical value, it was considered desirable that they be promptly reported and compiled so that the data might be available for comparative studies

as soon after the close of the month as possible.

The form used in the monthly reporting system is reproduced herewith. The definitions needed for the uniform recording of those statistics have been carefully worked out by the committee and adherence to them when reporting is strongly recommended by the committee.

The form makes provision for reporting the growing services rendered by general hospitals to private ambulatory patients.

"Private Ambulatory Patient as differentiated from an in-patient or out-patient is one who is referred to the hospital for one of the specific diagnostic, consultations or treatment services, such as x-ray, laboratory or physical therapy, and who does not occupy a regular hospital bed, and for whom no chart is originated.

"Such patients remain under the direct care of the referring hospital or physician. They usually pay an established fee for the services rendered and should always be registered as private ambulatory patients. These patients may be ambulatory or may be brought to and from the hospital in an ambulance, or they may not even come to the hospital, as when a specimen is referred for laboratory examination.

"Visits made by private ambulatory patients: The time or times a private ambulatory patient presents himself for treatment or examination or that such services are undertaken in his case. This figure represents only the number of visits and not the number of treatments or examinations given on the occasion of any one visit. A visit is to be recorded on the occasion of specimens being brought to the hospital for examination."

Determining Cost per Patient Day

The usual way of computing daily hospital per capita costs is to divide the current operating expenditures (total of items 1 to 10 of uniform chart of accounts) by the total hospital in-patient days. This method does not take into consideration (a) the cost of the out-patient department services and (b) the weight that infant days of hospital care should have.

Until such time as it will be possible to work out a satisfactory method for determining the cost of the out-patient department services (which will take into account both the direct and indirect costs), it has been suggested to allow \$1 for each

PLEASE RETURN TO: - DIVISION OF STATISTICS AND RESEARCH DEPARTMENT INSTITUTIONS AND AGENCIES TRENTON, NEW JERSEY			
HOSPITAL SERVICE SUMMARY REPORT		For the month of _____ 194__	
NAME AND LOCATION OF HOSPITAL _____			
BED COMPLEMENT	1	TOTAL BED COMPLEMENT (Total of items 2 and 3)	
	2	BEDS	
	3	RESIDENTS	
IN-PATIENTS ADMISSIONS AND PATIENT DAYS	4	TOTAL - ALL IN-PATIENTS (Total of items 5 & 6)	
	5	NEW BORN INFANTS (do not include still births)	
	6	TOTAL ADULTS & CHILDREN (Total of items 7, 8, 9, 10)	
	7	PRIVATE PATIENTS	
	8	SEMI-PRIVATE PATIENTS	
	9	WARD PATIENTS - PRIVATE	
	10	WARD PATIENTS - GENERAL	
	11	TOTAL RECEIPTS FROM ALL PATIENTS (Total of items 12, 13, 14, 15, 16, 17, 18, 19)	
	12	RECEIPTS FROM ALL IN-PATIENTS (Total of items 13, 14, 15, 16, 17)	
	13	RECEIPTS FROM PRIVATE PATIENTS	
RECEIPTS FROM PATIENTS	14	RECEIPTS FROM SEMI-PRIVATE PATIENTS	
	15	RECEIPTS FROM WARD PATIENTS - PRIVATE	
	16	RECEIPTS FROM WARD PATIENTS - GENERAL	
	17	RECEIPTS FROM OUT PATIENTS	
	18	RECEIPTS FROM PRIVATE AMBULATORY PATIENTS	
	19	RECEIPTS FROM ACCIDENT AND EMERGENCY CASES	
	20	TOTAL CURRENT OPERATING EXPENDITURES	
	OUT-PATIENTS	21	NEW OUT-PATIENT ADMISSIONS
22		OLD OUT-PATIENT ADMISSIONS	
23		TOTAL VISITS TO ALL CLINICS	
24		TOTAL VISITS TO AUXILIARY SERVICES BY CLINIC PATIENTS	
PRIVATE AMBULATORY	25	TOTAL VISITS MADE BY PRIVATE AMBULATORY PATIENTS	
ACCIDENTS	26	TOTAL VISITS TO ACCIDENT OR EMERGENCY ROOMS	

Signed _____
Date _____ Title _____

out-patient department visit and to deduct it from the total current operating expenditures of the hospital and to reduce four infant patient days to one hospital day.

Thus the cost per patient day is to represent the operating cost applicable to the care of in-patients only. The figure representing the cost per patient day is to be determined thus:

1. Take the total operating expenses of the hospital (combination of items 1 to 10 of the uniform chart of accounts).

2. Deduct the following: \$1 for each out-patient visit as defined and 60 per cent of the charges billed to private ambulatory patients.

3. Ascertain total in-patient days. Add to the adult and child in-patient

days one fourth of new-born patient days.

4. Divide the net current in-patient operating cost by the calculated number of in-patient days to secure the cost per patient day.

Advantages of Uniform Statistics

Each hospital administrator needs to know in detail what services his institution renders, how much each service costs and how the hospital income is derived. He wants to know these facts about other hospitals as well, so as to be sure his institution is functioning efficiently. Hospital trustees, to whom administrators are responsible, share this interest in knowing all there is to know about their hospital and how it compares with other hospitals of like size serving a like clientele. Such analyses can be made only if accounting and statistical methods are uniformly applied.

Uniform hospital accounting and statistical methods help solve troublesome problems in public relations. A frequent sore spot has been controversy between hospitals and contributing agencies, both voluntary and governmental, as to what represents adequate reimbursement for the care of the medically indigent. Regardless of how good a single hospital's system of accounting may be, it does not present the authoritative evidence made possible by figures arrived at under state-wide uniform accounting methods.

Should the present trend of rising costs continue, and this seems likely, increases in service rate schedules are inevitable. Individual hospitals can arrive at costs for the various services, and it sometimes seems as though they do, in just as many different ways. The establishment of mutually fair and reasonable rates is made possible only through the use of uniform accounting and standardized procedures for finding costs.

How much more confidence would the public have in the integrity of hospital rates if it could be assured that the rates were based on uniform, standardized cost accounting! How much more confident would the hospital administrators themselves be that the costs for their particular hospital were fairly computed if they had available figures from comparable hospitals arrived at by like methods of accounting!

Why Make a Habit of Deficits?

ERIC W. CRUSER

Assistant Superintendent, Paul Kimball Hospital, Lakewood, N. J.

OFTEN the rate structure of a hospital is based on a set of arbitrary figures. An investigation is made of rates charged by near-by hospitals or, in some cases when the hospital is more or less isolated, hospitals of similar size in various parts of the country are used as examples. This simplest way of attempting to solve the problem is justifiable in the case of a new hospital when there are no facts or figures for reference.

This solution would be entirely adequate if all hospitals were identical; however, they are not and probably fortunately so. Voluntary hospitals vary in size, construction, personnel, location, percentage of occupancy, quality and completeness of services and other characteristics.

Deficits require prompt attention if an institution is to continue to exist. Residents of a community must not be asked too frequently for contributions to make up a deficit or they will justifiably begin to question the management of the institution. A hospital that has a sizable deficit for two or more years in succession should promptly institute methods whereby the deficiency between income and expense is eliminated or reduced.

To this end, expenses may be cut, but it is difficult to retain the necessary specialty departments and still cut the operating expense substantially. The alternative is to increase the income.

Hospitals can learn much from successful private enterprises. In the industrial world the retail price of an article is determined by the actual

cost of production, plus such charges as are necessary for handling, storage, distribution and, finally, profit. Voluntary hospitals will not make an allowance for profit but they should try to charge enough to cover the cost. The operating expense is a basis on which the rates for service may well be formulated.

A hospital having a continuous deficit should first determine the additional income required and then consider doing several things: (1) room rates can be increased; (2) rates on x-ray, laboratory, physical therapy and other special services may be increased; (3) some new service with good income in proportion to expense involved may be in order.

A system of inclusive rates may be worked out that will bring in the required extra income and yet be favorably received by the public. Inclusive rates have the advantage that, in order to obtain this type of service, payment can be required within twenty-four or forty-eight hours after admittance of a patient. This practice will tend to decrease bad debts.

Often extra courtesies, particularly in little things sometimes overlooked, will bring additional patients.

A rate schedule should be reviewed every one or two years and readjusted if necessary. Hospitals have much better results if they solicit contributions for something tangible, such as a nurses' home or some item of equipment, rather than for an intangible deficit.

You Ought to Autoclave

ALBERT W. SNOKE, M.D.

Assistant Director, Strong Memorial Hospital, Rochester, N. Y.

PROCEDURES and equipment for sterilization in operating and central supply rooms have been improved so that one can be reasonably certain of sterile supplies in these departments. However, in the other departments of the hospital the technics of sterilization leave much to be desired.

It is surprising that more hospitals have not altered their ward procedures for sterilization to conform with the more rigid requirements deemed necessary in the surgery. Perhaps this is because most nurses and doctors have taken for granted that boiling water will kill all organisms and that cross infection does not exist in the hospital. Actually some spores can be killed only by boiling for many hours and cross infections may easily be caused by poor technic in the utility room.

The realization that the ordinary utility room technic might be unsafe prompted a comparison of present practices with the use of autoclaves. For more than a year we have been contrasting the customary method of sterilizing instruments and utensils in large sterilizers of the boiling type with that of treating them in autoclaves. It is our conclusion that the

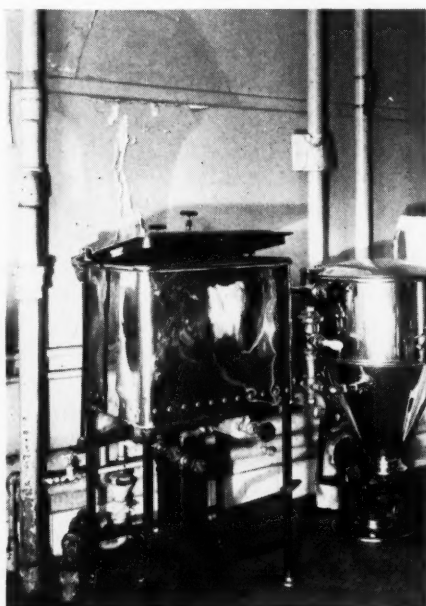
many disadvantages existing in the case of the boiling sterilizer have been almost completely eliminated by the use of an autoclave.

The standard equipment for sterilization on each hospital division consisted of a 20 by 20 by 24 inch boiling type of utensil sterilizer operated by steam and a small electric instrument sterilizer of the boiling type. Upon the divisions selected for this experiment 16 by 24 inch autoclaves were substituted. A combination bedpan washer and sterilizer was standard equipment upon all divisions. The ordinary equipment of the hospital divisions (syringes, tooth mugs, instruments, basins, bath tubs, catheters) was sterilized in the utility room by means of the autoclave. Needles, parenteral solutions, intravenous and subcutaneous parenteral fluid sets and dressings were sent as usual to central supply.

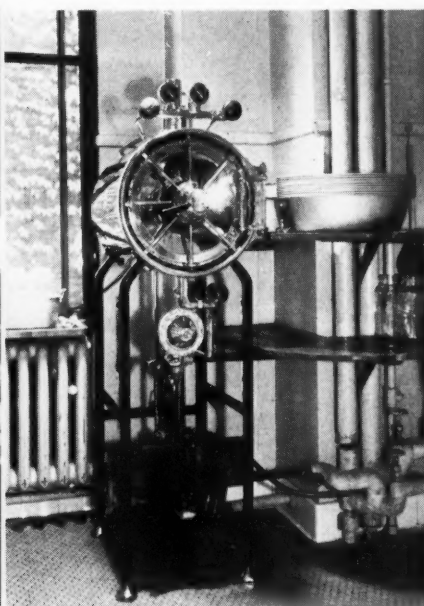
The advantages of the autoclave over the ordinary boiling type of sterilizer were:

1. *Shortened Sterilizing Time*—Comparison was made of the length

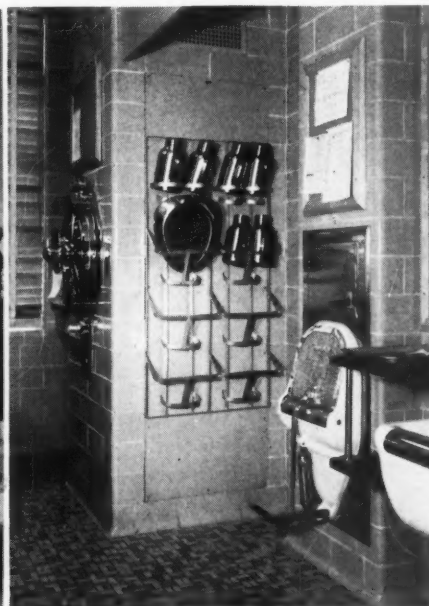
of time required to prepare and sterilize a load of equipment by the two methods. The time of preparation and of loading in each case was approximately the same, namely, from four to six minutes. The filling of the 20 by 20 by 24 inch sterilizer with ordinary tap water to the level recommended for proper sterilization and the bringing of this water to a temperature of 212° F. took ten minutes, after which the sterilizing period occupied twenty minutes. This period of thirty minutes is in sharp contrast to a total of seventeen minutes required by the autoclave: from one to two minutes to bring the autoclave to a sterilizing temperature, followed by a fifteen minute exposure to a temperature of 250° F. at 15 pounds' pressure. The unloading time of both sterilizers was approximately the same, namely, three minutes. If the water in the 20 by 20 by 24 inch sterilizer was warm to start with, the time necessary to bring the water to boiling was less, but in any case a saving of from ten to fifteen minutes per load of



Escaping steam from a sterilizer of the boiling type ruined wall.



Autoclave installed in old room. See gauntlet gloves for loading.



Recessed autoclave installed in utility room of a new addition.

material was found with the autoclave.

2. Completeness of Sterilization—Comparison of the two types of sterilizers leaves little doubt that the autoclave is far more efficient in sterilization. For example, it is difficult to kill spores by boiling. This in itself is not felt to be an important disadvantage in an ordinary boiling type of sterilizer, as the utensils and instruments, for most practical purposes, are sterile after twenty minutes of boiling. The greatest difficulty is in determining whether an article has actually been boiled for twenty minutes and whether a boiling temperature has been continually maintained. To be absolutely sure, someone must turn on the steam after the sterilizer is full, wait until the water begins to boil and then start timing.

Actually, this practice is not always followed. Rather, the sterilizer is frequently filled with utensils, the steam is turned on and ten or fifteen minutes later, when the sterilizer is boiling strongly, the utensils are removed. Obviously, in this case there has been an inadequate period of sterilization. This is a personnel problem that is difficult to solve in spite of persistent instructions to the nurses and division helpers. The autoclave, on the other hand, sterilizes completely in a few minutes; the ordinary ten to fifteen minute period after the steam is turned on provides a large safety margin. Of course, breaks in technic can occur in the operation of the autoclave, but the autoclave's larger safety factor makes it desirable for use upon the division.

3. Elimination of Noise and Steam—Two of the complaints frequently made about the ordinary boiling type of sterilizer are the noise during operation and the escape of steam into the utility room. The escaping steam causes a continual maintenance problem, as it is virtually impossible to prevent it from causing deterioration of walls and ceiling unless tile is used. Correctly installed atmospheric vents are efficient and dissipate excess vapor during the sterilizing period, but it is impossible to avoid a cloud of steam when the cover is being raised to load and unload the sterilizer. The condenser or suction type of vent is fairly efficient but is disagreeably

noisy and the personnel frequently overlooks its operation. Moreover, it does not overcome the discharge of steam when the cover is raised.

A newer and more efficient means of eliminating excess vapor is the automatic control for regulating the boiling temperature at the source of supply. The apparent objections involve a maintenance problem in checking the thermostatic control at regular intervals so that the thermostat may be adjusted to maintain a boiling temperature. The autoclave is quiet and releases no steam into the room except for a moment when the door is opened.

4. Improved Appearance of Utility Room—The boiling type of sterilizer occasionally boils or spills over and, because of the length of the sterilizing period, soiled utensils frequently collect, waiting to be sterilized. The autoclave handles quickly and efficiently the material of the largest surgical division of the hospital averaging about 38 patients and is an important factor in enabling the nurses to keep the utility room neat.

5. Preservation of Equipment—There is always an appreciable amount of breakage and deterioration of equipment in the utility room. Glassware is broken and enamelware chipped because of being "bumped" when boiled. Syringes leak after being boiled a great deal, principally because the precipitation of phosphates and carbonates upon the plungers and upon the inside of the barrels results in an abrasive

action of these salts as the syringe plunger is moved in and out. Scissors and scalpel blades are quickly dulled and metalware becomes discolored from a deposit of scale.

It was difficult to compare accurately the breakage and deterioration under the two systems, but it is our impression that the autoclave is more economical. Scissors and knife blades are not dulled, syringes are not broken, there is no deposition of carbonates or phosphates and the glass breakage is diminished because of the elimination of "bumping."

It must be mentioned, however, that ordinary glass utensils break easily in the autoclave and the enamelware does not stand up too satisfactorily. Whenever possible, heavy glass or aluminum utensils should be substituted for the usual graduates, dressing jars and instrument pans of the utility room. Cypress wood should be used to support the glassware in the sterilizer. If a dull aluminite finish is used with all the aluminum ware, the finish will remain unaltered after repeated autoclaving.

All types of equipment can be sterilized simultaneously without undue esthetic objection at the juxtaposition of emesis basin and tooth mug.

6. Lowered Cost of Operation—Studies were made of the steam consumption of the boiling type of sterilizer and of the autoclave. The condensate in the return steam lines was measured to determine the amount of steam used during a specified period. The average amount of steam required to bring the water in a 20 by 20 by 24 inch sterilizer to a boiling temperature and to maintain this temperature for twenty minutes was approximately 40 pounds. There was an average of 12 sterilizing loads a day, causing a consumption of approximately 480 pounds of steam each day. In addition to the use of the large boiling sterilizer, a small electric sterilizer was in almost constant use for syringes, instruments and catheters.

In using the autoclave it was found most economical to turn on the "jacket" steam in the morning and to maintain the jacket pressure throughout the day until sterilizing was finished in the evening. The amount of condensate, the number of loads and the hours operated were

Daily Steam Consumption of 16 by 24 Inch Autoclave

(Jacket Kept Heated During Entire Day)

C.C. Water	No. Loads	No. Hours Operated
32,000	11	16
60,500	13	14
29,000	9	13
53,000	14	12
32,000	10	14
43,900	10	12
40,900	11	13
22,000	7	17
54,500	16	17
33,450	14	23
31,200	14	24
37,600	13	22
51,500	9	18
521,550	151	215
Daily Average:		
40,119 cc. = 11.6 loads 16.5 hours operated		
88.3 pounds		
88.3 pounds = steam used a day		
7.6 pounds = average amount of steam per load		
5.3 pounds = average amount of steam per hour of operation		

noted for a thirteen day period. An average of 5.3 pounds of steam condensate per hour of operation was found with a total daily steam consumption of less than 100 pounds.

Cost of steam varies in different hospitals, but at the rate of 55 cents per thousand pounds of steam, the present cost in our own institution, a minimal saving of from 300 to 400 pounds of steam a day represents a saving of from \$60 to \$80 a year per autoclave.

The disadvantages of the autoclave over the boiling type of sterilizer were:

1. The necessity for specific types of glassware and metalware, already mentioned. This is not felt to be important, for the equipment obtained will last indefinitely and the appearance of the equipment is not impaired.

2. The instruments are very hot after sterilization. Occasionally, a nurse has burned her arm when reaching into the autoclave. The use of a pair of long gauntlet gloves will overcome this objection.

3. Sterilization of rubber goods, gloves and catheters is not yet completely satisfactory. Theoretically, fifteen minutes at 250° F. should not deteriorate rubber goods. However, a definite evidence of deterioration of the rubber was found on some of the divisions but not on others. The possibilities of inferior rubber, improper cleaning of lubricants from catheters and inadvertent lengthening of the time period of sterilization have been considered and investigation is being continued on this subject.

4. Replacement of autoclave door gaskets is another problem that is probably aggravated in the present emergency by the difficulty in procuring normal supplies of uniform quality. No matter how short one makes the handles of the autoclave door, there is a tendency of the operator to tighten the door far more than is necessary, thus destroying the gasket. These have to be replaced at intervals, but this is the only real maintenance item.

5. The initial cost of the autoclave as compared to that of an ordinary boiling sterilizer is another disadvantage, for the autoclave, in general, costs about twice as much as the nonpressure sterilizer. However, it is felt that this extra cost is justified by the saving in maintenance, nursing

Service Island for Surgery

GEORGE D. SHEATS

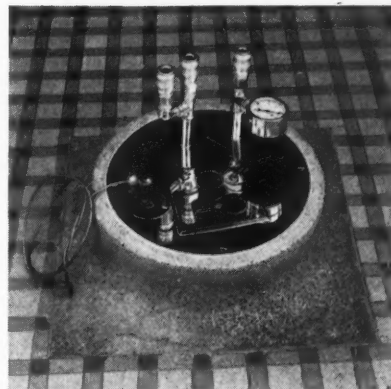
Administrator Baptist Memorial Hospital, Memphis, Tenn.

IN A recent remodeling program of nine minor operating rooms at Baptist Memorial Hospital, Memphis, Tenn., it was decided to deviate from the orthodox method of supplying air and current in these rooms by constructing what we call a "service island."

This service island provides all of the necessary services at each operating table, eliminating all tubing and wires extending from sidewalls. It is an integral part of the operating room floor but is circular in design and rises 4½ inches above the floor, to facilitate the making of repairs and connections. The top is a removable stainless metal plate.

Contained in this island are two negative air connections with a special automatic valve for suction use in all operations, a positive air connection for purposes of anesthesia, a low voltage receptacle with variable rheostat with from six to twelve volts for use with head lamps, a twin receptacle for 110 volts, a ground connection for the operating table and, in three rooms, a flexible drain connected to the GU table for use in resections and cystoscopies.

At the time of construction, there was some skepticism with reference to the operation of these islands, but they have been in operation for eighteen months and we have found them to



be highly satisfactory to surgeons and operating room personnel.

Along with this island we designed a portable x-ray viewing box, simple in construction but convenient for the surgeon since he does not have to leave the table during an operation.

Another interesting accessory used in this setup is a two way intercommunicating system with the master set in the supervisor's office from which are relayed messages to operating surgeons, requests for additional instruments and for assistance.

Numerous favorable comments from surgeons who use these rooms almost daily have convinced us of the fact that these improvements have proved to be in every way satisfactory and advantageous.

ing time, deterioration of equipment and actual demonstrable saving in steam consumption, in addition to an improved technic, which perhaps should be given first consideration.

The use of an autoclave in place of the usual boiling type of sterilizer was tried on an ordinary hospital division for a period of six months. As a result of the tests made, autoclaves have replaced boiling sterilizers on four surgical divisions and one private division of Strong Memorial Hospital. The boiling type of sterilizers have been removed and autoclaves placed in the utility rooms. In the new wing of the hospital, recently completed, recessed autoclaves have been installed in the utility rooms. Three additional auto-

claves will replace the boiling type of sterilizer within the next year.

All nurses who have worked with the autoclaves are emphatic in preferring them to the boiling type of sterilizer. They are particularly pleased with the saving of nursing time owing to a shorter sterilizing period, the cleanliness of the utility room, the lack of noise, steam and confusion, the continued satisfactory appearance and condition of the equipment and the added efficiency of sterilization.

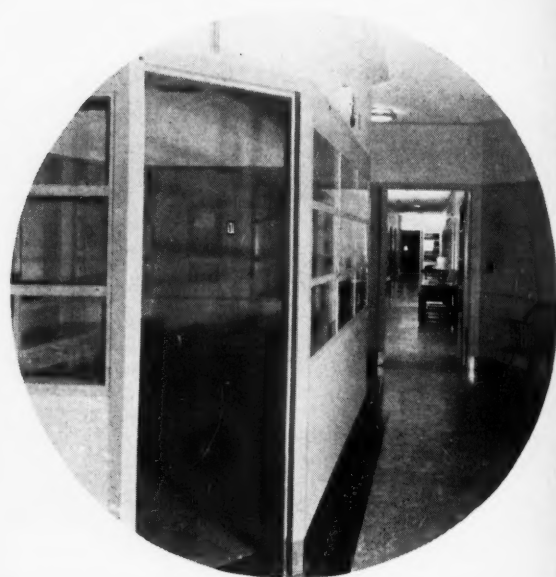
The author wishes to express his appreciation for the assistance and helpful suggestions of Norman Robson of the Wilmot Castle Company and Mr. Weeden B. Underwood of the American Sterilizer Company in the studies upon sterilization and in the preparation of this paper.

New Psychiatric Unit

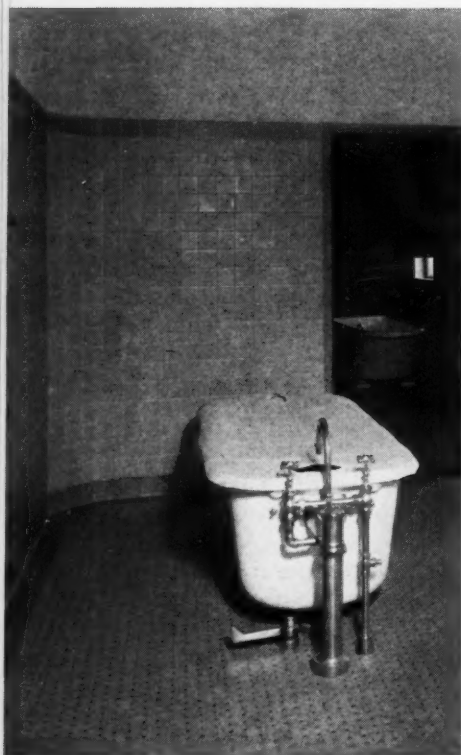
Twenty women live during the most disturbed phases of their mental illness in this beautiful new Nichols Memorial Cottage at New York Hospital-Westchester Division, White Plains, N. Y. The cost per bed was \$11,000 or, roughly, 75 cents per cubic foot. Charles E. Crane with Edwin A. Salmon as consulting architect, both New Yorkers, designed the cottage.



North foyer of air conditioned cottage; sounds cannot carry outside.



The glass enclosed, centrally located nurses' station permits the constant observation by one nurse of the two corridors, the sitting room and dormitory.



Continuous flow tub room, showing washroom with an immersion tub.

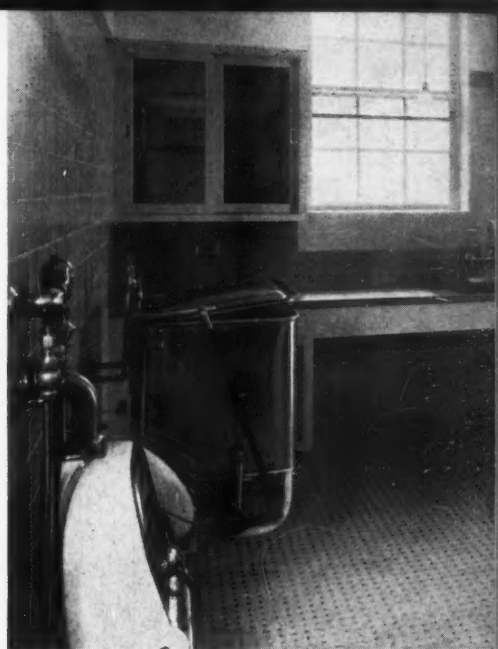


The restful, warm and attractive interiors, such as this main sitting room for patients, are achieved by the use of colorful window draperies, furniture and upholstery fabrics.

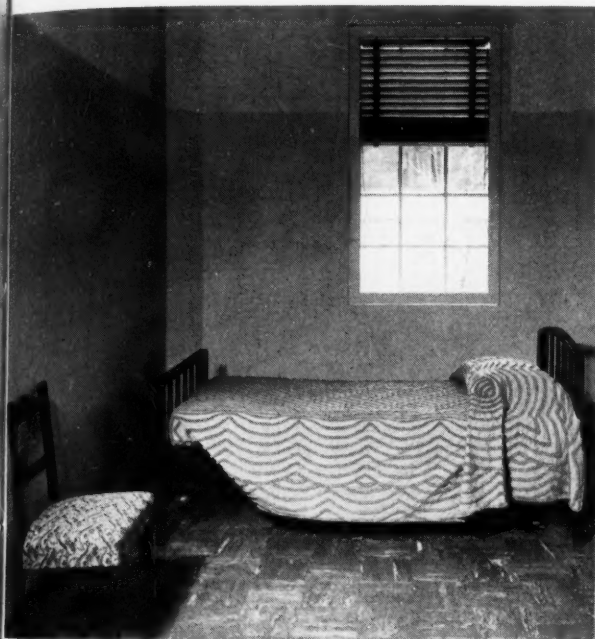
SEE PAGE 68 FOR FLOOR PLAN OF COTTAGE



There is a therapeutic value for these patients in tasteful decoration. Rooms combine the utmost in safety without sacrificing either comfort or beauty.



Utility rooms such as this and treatment rooms are well located and equipped.

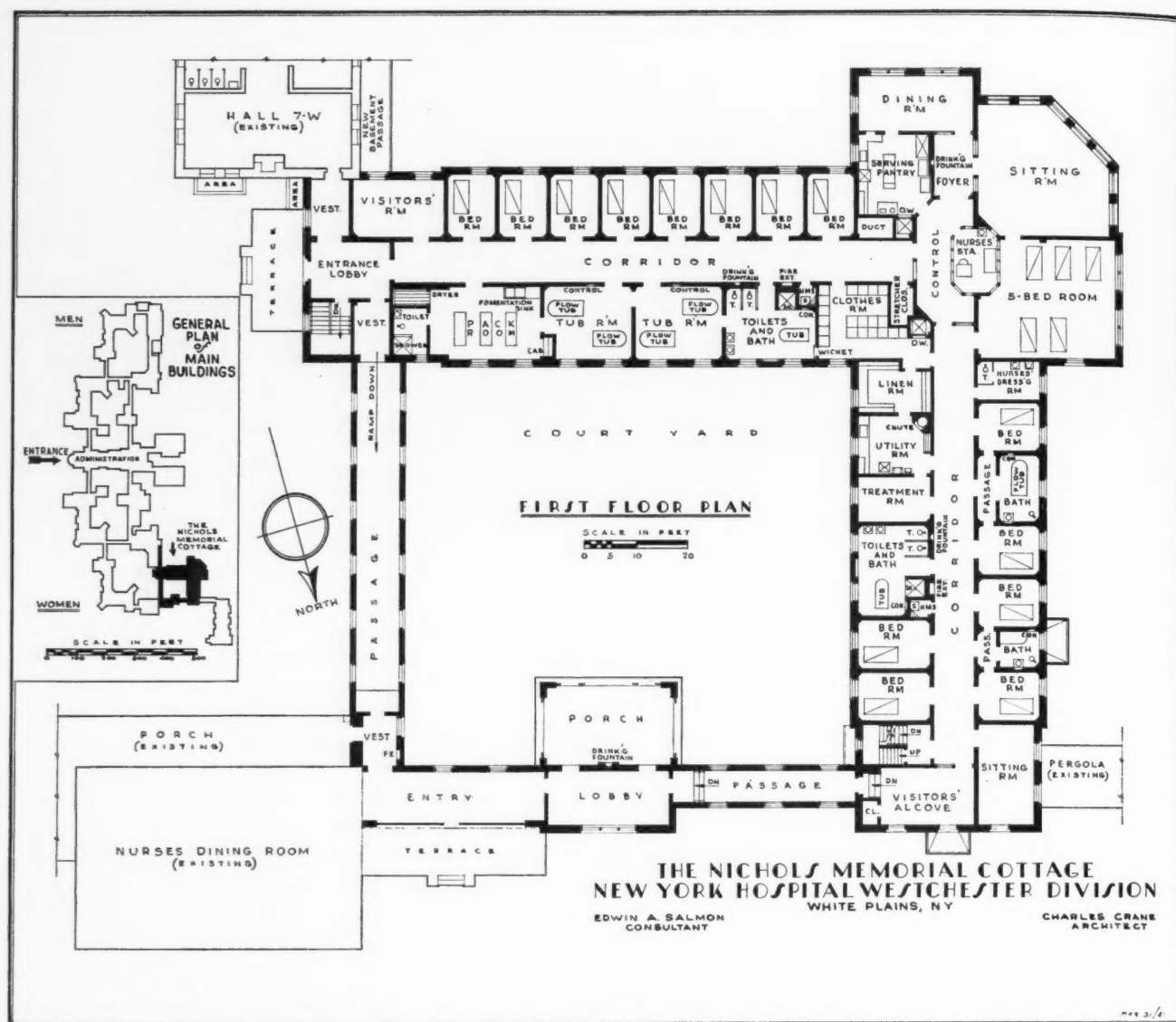


Note in the single bedroom and the dormitory the unobtrusiveness of the safety screens. The venetian blinds are placed between the screen and the sash so they are not accessible to patients. The safety screens have a tamper-proof lock, the key of which cannot be removed unless the screen is properly locked. The cottage has 14 single bedrooms and one six bed dormitory. Partitions and doors are soundproofed and sound reverberation is reduced by acoustical plaster on all ceilings and parts of the sidewalls and by rubber tile floors.



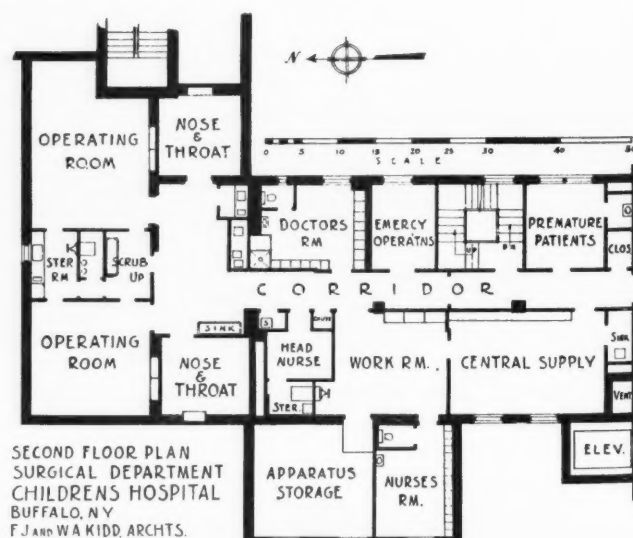
Well-equipped pantry. Plastic dishes are used for the less comfortable patients.

NICHOLS MEMORIAL COTTAGE



CHILDREN'S HOSPITAL, BUFFALO

Four operating rooms, an emergency room, doctors' and nurses' locker rooms and a storage room, along with ample work space, give Children's Hospital an adequate surgical department. This hospital was the first in the United States to make use of conductive rubber flooring to minimize the danger of explosion resulting from static electricity. Casters, tubing, breathing bags, face masks and the soles of nurses' and doctors' shoes, all are of conductive rubber. Among the new equipment are the following: instrument, water and dressing sterilizers, recessed view boxes with fluorescent lighting, suction machines, an electro-surgical unit and cautery knife, resuscitator, inhalator and stainless steel furniture. Other hospital departments have also been partially reequipped.



Remodeling Job

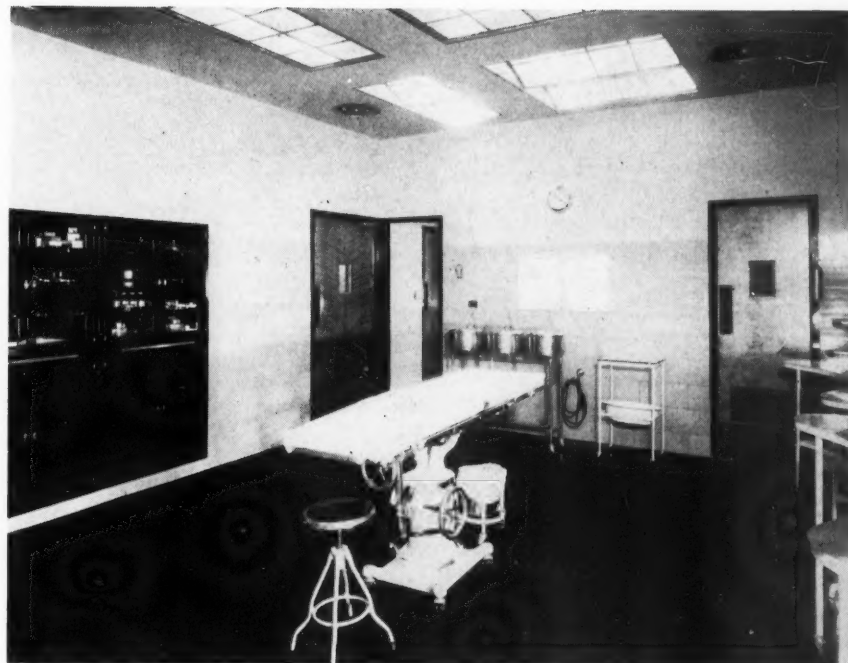
CHILDREN'S HOSPITAL, Buffalo, N. Y., has spent \$125,000 recently and to show for it has a great deal of new equipment and two completely remodeled departments.

The contagious disease building has been modernized, to bring it in line with changes in technics in caring for the communicable disease patient.

Now visitors may enter the corridors and see the patients through windows provided for that purpose. Between each two units is a utility room containing proper sterilization facilities, including bedpan, urinal, utensil and instrument sterilizers. A scrub sink, cabinet and laundry hamper complete the equipment of these small units.

A new surgery is provided in this building, it being finished with blue metal wall board.

From the first floor waiting room a loud-speaker system permits parents to talk to their child. Also, the small

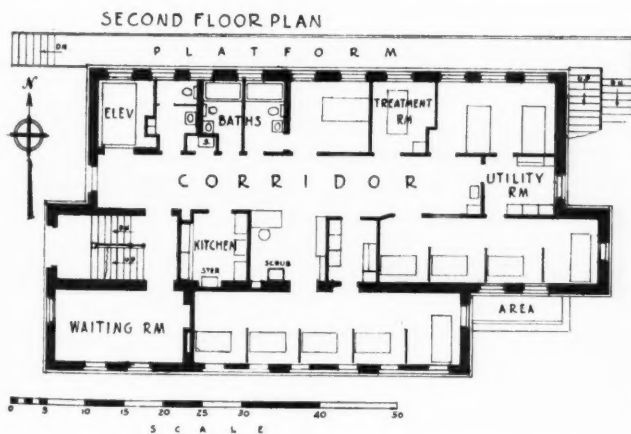
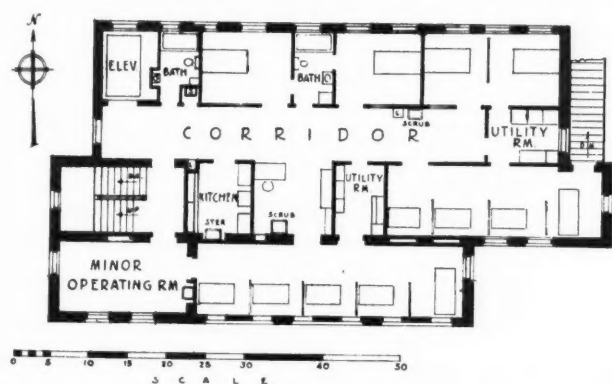


patients are kept amused by stories told over the loud-speaker system and by selected radio programs.

The old surgery was more than 20 years old and looked it. Walls were ripped out and with only the exterior walls and floors left, the transformation began. Not only was the existing space utilized but a 25 per

cent addition to the building was constructed.

Air conditioning was installed, air changes now being possible every four or five minutes; an electric precipitator is used for air cleansing. The unit is soundproofed as well. Other departments of the hospital also were altered and reequipped.



FIRST FLOOR PLAN
CONTAGIOUS DISEASE BUILDING
CHILDRENS HOSPITAL
BUFFALO, N. Y.
F. J. AND W. A. KIDD, ARCHTS., BUFFALO, N. Y.



Green tile walls, conductive rubber flooring, air conditioning, soundproofing and new equipment have been added.

Hospitals Now Face Shortages

TO DATE the hospital field seems to be divided into two fairly equal groups as far as the effect of shortages of materials and supplies are concerned. In group 1 are the hospitals that have not yet experienced shortages serious enough to interfere with proper care of hospital patients. In group 2 is a somewhat larger number of hospitals that report that shortages are already making serious difficulties.

An inquiry sent out on this subject on June 22 brought forth by July 8 a total of 41 replies in group 1 and 55 replies in group 2.

A New England hospital administrator, who has been successful in meeting all important needs for his hospital, sends some interesting comments and excellent advice to other hospitals.

In Luck

"We have just finished a new building," he writes. "We experienced annoying delays in obtaining furniture and furnishings, operating room tables and motors, but most of our furnishings and equipment have now been received and we expect to obtain all that we require within a brief period.

"In our contagious disease department, one of the two boilers that have been in service for thirty-five years was examined by the insurance inspectors at our request and was found to be in such condition that it could not be repaired. This was a return tubular boiler of 100 h.p. at 125 lbs. steam pressure. The boiler-maker required an A-1-j priority rating or better and this morning (June 29), after making our formal application, this priority certificate has been received. Our application was dated June 16 at Boston and the certificate was dated June 24 at Washington. . . .

"I believe the great reason why hospitals report that they have difficulty in obtaining supplies and equipment is because the administrator or purchasing agent does not know just how to proceed to obtain them. If you could bring about a

ALDEN B. MILLS

better understanding on the part of hospitals of the whole question of priorities, it would be of great benefit. Perhaps the time has arrived when priorities will remain unchanged for such a period as to make it worth while to put such an article in type. I have found the personnel of W.P.B. eager to assist in every way possible."

In Difficulties

Among the hospitals that report more or less serious difficulty in obtaining needed supplies and equipment, a Baltimore hospital stands out as having the most serious present problem.

On May 21 the administrator wrote that the purchase of new boiler equipment and accessories was necessary because of condemnation of the boiler by insurance inspectors but that the W.P.B. had refused to grant a sufficiently high priority. He added that unless the hospital could obtain a safe boiler it would have to close its doors for the duration.

"This, indeed, is a sad commentary," he declared, "when one realizes the full significance of throwing more than 235 patients on other local institutions now overcrowded and understaffed." On June 30, the situation was still unchanged.

Other typical shortages reported can best be summarized according to the class of shortage.

Air Conditioning Repairs.—"The only serious interruption to our service has been failure to obtain repair parts for our air conditioning equipment. This has meant that on several occasions we have had to cancel operations owing to lack of cooling and ventilating facilities."—Baltimore.

Alcohol.—"We have felt a serious reduction in quantity only in the matter of alcohol."—St. Louis.

Beds.—"One hundred beds were ordered last February and have not yet been delivered. We are told that the metal parts for the springs are

not available. We are seriously handicapped."—Rochester, Minn.

Boiler and Power Plant Needs.

In addition to the Baltimore hospital mentioned earlier, the following needs were reported:

"This hospital has some trouble in getting the following supplies for maintenance and replacement because of low priorities: galvanized and black pipe, steel, copper and brass bars and fittings for the boiler room; aluminum for surgery; rubber cord and copper wire for bell cords."—Portland, Ore.

"A breakdown in the generator equipment of a hospital for special surgical procedures in New York City occurred about six weeks ago and has not yet been taken care of."

Blood Bank Equipment.—"Six months' delay was experienced by one of the local hospitals in obtaining complete blood bank equipment. This created much inconvenience. The last of this equipment has finally been received."—Fort Worth, Tex.

Building Needs.—"We have all plans completed and the approval of the government for a loan of \$265,000 for a wing on our hospital giving us 130 additional beds. This has been held up by W.P.B. but is now being reviewed for the third or fourth time since we have eliminated practically all critical material."—Indiana.

"We have crowded all the nurses we possibly can into the nurses' residence and have enough applicants for a class in September if we have a place to house them. There are no large houses in this section and some type of emergency housing seems necessary. We cannot, however, get a program approved because this is not a defense area, although as a matter of fact the training of student nurses is definitely a defense program."—Indiana.

Call Systems and Telephones.

"After making out several forms upon at least two different cases, the W.P.B. finally reported that the cords for call signals were not deemed essential to the welfare of the civilian population; therefore, a higher priority rating could not be

of Supplies and Equipment

granted. Just how you can operate a hospital without your patients' call system is beyond us and we venture to guess that whoever made the rule for W.P.B. knows little about a hospital's needs."—Kentucky.

"My experience with PD-1-A forms has, in general, been very bad. As near as I can discover, the fault is the lack of a hospital trained person to look over the requests for hospital priority ratings. On March 16, I sent in a PD-1-A form for 4000 feet of No. 16, rubber covered telephone wire. Somewhere about March 30, I received the form allowing me the ridiculous A-10 rating. I had stated, and it was true in industry generally, that an A-1-j or better was necessary to get wire. Can it be that Washington didn't know that? The final result in this instance was that the supplier himself over the course of the following three or four weeks was able to get the rating up high enough for me to obtain the wire."

Electrical and Plumbing Equipment (Including Lighting).—"We have had the experience of having our orders turned down for such items as wall receptacles used for pilot lights in the ironing rooms in which we iron the nurses' uniforms. We have also been refused such items as vacuum jugs and ordinary wall switches. In any institution these articles wear out from time to time and must be replaced."—Kentucky.

"We had the utmost difficulty in obtaining copper wire. Notwithstanding the material had been ordered in May 1941, delivery was not made until March of this year. With the new addition now completed, we are having to operate with bare light bulbs in corridors because of the contractor's inability to get delivery on the fixtures. . . . We shall shortly be out of plugs for the electric irons in the laundry and I am told it will not be possible to obtain replacements."—New York.

"Recently we placed an order for six circuit breakers for our power plant. The supplier notified us that he could not accept the order unless

we obtained a better rating than A-10. We filed an application and, after waiting two weeks, our application was approved and the order is on the way, I hope. It seems to us that a better rating should be made available to hospitals so that parts for equipment could be obtained without so much delay."—Pennsylvania.

"We are having difficulty in getting the necessary parts to repair a badly leaking valve on the foot-pedal operated doctors' scrubup sink in the operating room."—Wisconsin.

Centrifuge.—"We have had an order placed for a centrifuge for our laboratory department for several months and have been advised by the suppliers that they cannot promise us shipment for ninety days. Our old centrifuge is worn out."—Iowa.

Elevators.—"I have been trying to get one article from the General Electric Company for several months and received a letter from them this morning stating that I would have to furnish at least an A-1-j rating to obtain this item. If it had not been for a local second-hand house being good enough to lend me this instru-

ment, we would have been unable to run the elevator."—Tennessee.

Film for Medical Records.—"Our records storage space has been almost completely filled for about a year. During this period we have been unifying our records with the aid of a W.P.A. project with the idea that the older records would be filmed as soon as possible. However, we have been refused permission to rent the machine or to obtain the necessary film."—Minnesota.

Kitchen Equipment.—"We have experienced considerable delay in obtaining a decision regarding our application for a preference rating to cover the replacement of a worn-out coal range with a gas range. Our first application was made May 29, 1942, to the Division of Industry Operations. Prior to that we had some contact with the local office. On June 4 our application was returned to us because we had not specified an exact date of delivery requested on the stove. This was returned to Washington the same day. Several days ago, we received a reply referring us to Preference Rating Order P-84, which our local

Shortages

We're short of interns, porters, nurses;
Short of sugar. What is worse is
Folks are short of temper, too;
Don't know what we're going through.
Supplies are less and prices higher;
Life is hell for any buyer.
We're not short of questionnaires.
By the hundreds, dozens, pairs,
They keep coming; but we're short
Of clerks to find the right retort.
Short of drugs and alcohol;
Short of items large and small.
Pretty soon, like sundry sports,
We'll be doing work in shorts.
Long on headaches; short on sleep.
On our heads short words they heap.
Short of rubber, gas and tin.
Thank Thee, Lord, for aspirin.

* * *

What with all things getting shorter,
Save my troubles, which increase,
I've a mind to join the Army
Just to get some rest and peace.—J. H.

office says does not apply to our application. We have again written Washington. Thus in one month's time we seem to have progressed very little."—Missouri.

Other hospitals mentioned the inability to obtain steam cookers, stoves and potato peelers.

Laundry.—Many hospitals mentioned difficulties with laundry equipment. One example follows:

"We have been seriously handicapped because of our extractor, which is insufficient in capacity owing to the expansion of our building, and is also old and in need of repairs. When we have to repair our present extractor we shall have none and I doubt if we shall be able to carry on the laundry work for our institution efficiently if we are forced to operate with this one extractor."—Ohio.

Operating and Delivery Room Equipment.—"We have two articles now held up. One is a delivery obstetric bed because of the difficulties in getting the right type of casters."—Michigan.

"Orders that were placed three or four months prior to the opening of our new maternity building in February were not on hand. This applies to delivery room lights, operating room table, bassinets. We had to make the best of the situation and get along as best as we could."—Wisconsin.

Pins and Safety Pins.—"We made an application for an A-3 rating for pins and safety pins more than two months ago. We have just been notified that the form on which we made that application has been superseded by a new form and it will now be necessary to make an entirely new application."—New York.

Pumps.—"Since April we have been trying to secure a pump for a new well. So far we have been unsuccessful."—Minnesota.

"We are in need of a centrifugal pump to replace one already worn out. The pump is able to increase the water pressure to the higher floors of our building, particularly our surgical and obstetrical divisions, in which departments we suffer from low pressure. Many times during the past year the doctors have been unable to scrub because of the poor water supply. We have not received a priority to purchase this equipment."—Ohio.

Refrigeration.—"Our present refrigeration system is beyond repair. It is liable to cease functioning at any time. An order for a new unit was placed about a month ago. It seems there is some difficulty in getting the necessary material."—Wisconsin.

"Recently we had a breakdown on the compressor of the refrigerator in the milk laboratory. We have applied to Washington for a suitable priority, but as yet same has not been received. With 90 babies in the nursery, this can be a serious situation. Our local dealer has a complete new unit, which he is ready to install if we can get the priority."—New York.

Rubber Tubing.—"We have been unable to obtain pure gum rubber tubing for intravenous preparations. We will use up the last we have on hand during the next two weeks and have been attempting to locate this material for something over two months."—Louisiana.

Sterilizers.—By far the largest number of difficulties reported involves sterilizers or repairs for them. Here are some examples:

"We have experienced some difficulty in obtaining copper coils for sterilizers. It was suggested that we use galvanized iron coils which, of course, are not suitable for the purpose."—Pennsylvania.

"We met our first difficulty this week when we ordered replacement parts for a steam control valve on our sterilizer. We must first obtain a preference rating of A-1-j or better, which, you know, is a time consuming procedure."—Indiana.

"We placed an order on Dec. 29, 1941, for new sterilizers and a still, which are dire necessities. After considerable correspondence we received a higher priority rating which was sent directly to the company and we don't know just when to expect shipment."—Indiana.

"We placed an order in September 1941 for a pair of water sterilizers but the new equipment was not installed until April 1942. This delay was hazardous."—Ohio.

"At present I am having difficulty in obtaining bedpan washers and sterilizers, instrument sterilizers and warming cabinets for the new addition, which will be ready for occupancy around October 1. I wrote to Washington and obtained a rat-

ing of only A-3. The suppliers wrote me that they would be unable to furnish equipment unless we had a rating of A-1-j or higher. I heard today that several hospitals have received that rating for sterilizers, so perhaps if I state my case more clearly I will, too."—Pennsylvania.

Stokers.—"Our biggest problem at present is in procuring the proper priority to purchase three stokers for our boiler plant. For the last ten years we have purchased steam from the university and now that it is impractical to pursue this policy we want to resume use of our own boiler plant."—Missouri.

"We recently ordered from the manufacturer some very small copper disks, which probably did not weigh more than 1 pound. We were told that we would have to obtain an A-1 rating to obtain these essential repairs. These copper disks make it possible for us to operate a motor control stoker in one of our boilers. Without them the stoker and the boiler will not work. We made a request to Washington several weeks ago but have received no reply to our letter. We have another boiler for just such an emergency but we cannot run one boiler indefinitely without cleaning and repairing it."—Virginia.

Tires.—"Several married nurses who have not worked regularly for years are now willing to come in to assist in the hospital. Some of them live in the country and need retreads for their tires. We cannot operate without these people."—Wisconsin.

X-Ray Equipment.—"We have all the equipment but cannot secure the wire to complete an installation that is being made to speed up our service."—Iowa.

"I now have a PD-1A form for some \$2500 worth of x-ray equipment, which has been in for some three weeks. It was returned to us with an A-2 rating (after a definite request for an A-1-j or better on the part of the company) and to date, in spite of the valiant efforts of the W.P.B. to expedite this application, I have not had a single word. This x-ray equipment will be used on defense workers."—New York.

The original letters have been forwarded to Washington with the hope that many of the problems can be solved.

The Field Nurse

in the Control of Tuberculosis

TIME has wrought many changes in the field of tuberculosis control. The tuberculosis death rate in the registration area of the United States has declined from 160.3 in 1910 to 45.9 in 1940. Consequently, the scope of the tuberculosis problem is but a fraction of what it was three decades ago. At that time countless numbers of desperately ill patients were cared for in meager homes; poverty was more widespread; diagnostic clinics were practically nonexistent; no objective case finding programs were in force; tuberculosis hospital or sanatorium beds were few in number, and public health education was in its infancy.

During this period the place of the specialized nurse was established. At that time there were good reasons for the inauguration of this specialized service. Public attention was focused on tuberculosis and subsequently on one disease or health hazard after another. Organizations or groups became interested in a special problem and made it their responsibility to promote a service with which to meet it. The number of nursing specialties increased and consequently a pathway was worn to many homes. This was before a comprehensive general health program was organized.

Especially during the past two decades, there has been an encouraging increase in the development of public and other antituberculosis facilities. The number of tuberculosis hospital beds has been multiplied severalfold; diagnostic chest clinics are more generally available; various methods of case finding are used; our knowledge of the epidemiologic, clinical and economic aspects of the disease has greatly increased; the economic status of the average family is higher; technics and methods of public health education have been developed and put into effective operation.

As a result of more education and better training, nurses are no longer forced to blunder through experience after experience in this field of human service. Intelligent direction by

health officers, directors of tuberculosis hospitals or clinics, as well as generalized nursing supervisors, and guidance by specialized consultant nurses have contributed to the achievements of well-coordinated, economical and efficient generalized nursing service.

A tuberculosis program should attack the problem on all fronts; in every field of work and service the public health nurse is indispensable. Such a program should embrace case finding, segregation and hospitalization of cases, home nursing assistance and supervision of cases and contacts, follow-up of cases discharged from hospitals and industrial and social rehabilitation.

A review of but a few of the known facts regarding the character

A strong proponent of generalized nursing service, Doctor Plunkett here answers Doctor Pollak, who in May presented the case for specialized nursing for tuberculosis

and distribution of cases of tuberculosis in a community would warrant but one conclusion, namely, that in case finding a generalized type of service offers a contribution beyond the fondest expectation of an advocate of specialized service. Twenty years' experience in conducting consultation chest clinics for the examination of contacts and persons referred by their physicians because of symptoms has demonstrated as high a yield of new cases among those with symptoms as among the contacts. While this chest clinic service has consistently produced a higher

yield of new cases than any other type of case finding program, it would be only one half as great if only contacts were examined.

Data on the reporting of tuberculosis cases furnished additional evidence of the extent of unrecognized tuberculosis in upstate New York, where, it may be assumed, the circumstances are at least equal to, if not more favorable than, those in other states. Twenty per cent of the deaths in 1941 were not reported as cases at the time of death. Moreover, only 46 per cent of all cases were reported one year or more before death and but 27 per cent of cases were in the minimal or early stage when reported.

When it is realized that the average life of a tuberculous patient is at least five years from the date of onset of the disease, there must be more unrecognized tuberculosis than is ordinarily estimated. Moreover, there is little doubt but that the person who does not realize he has infectious tuberculosis is a greater source of danger than the diagnosed and instructed case.

Most of these tuberculous persons live at home; consequently, the more homes that have the benefit of generalized public health nursing the greater are the potentials of case finding. The relatively high incidence of tuberculosis among persons in the lower economic brackets adds emphasis to the part the nurse may play in helping to uncover hidden cases of the disease, for it is to the underprivileged that the public health nurse devotes a considerable portion of her time.

It should be obvious, therefore, that in contrast to the limited opportunities available to the specialized nurse because of the restricted scope of her service, a generalized nurse, by virtue of the greatly increased number of homes in which service

ROBERT E. PLUNKETT, M.D.

General Superintendent of Tuberculosis Hospitals
New York State Department of Health

is rendered, is one of the best mediums for the promotion of case finding. Without neglecting known cases or contacts, the well-trained and experienced public health nurse, by her alertness and recognition of symptoms, especially in an older person, may use the circumstances relating to a sick child, a pregnant mother or a nutritional problem as the one potent influence in obtaining an indicated chest x-ray.

While it may be possible to develop a more immediately efficient clinic service when a specialized nurse is constantly in attendance, such a service does not necessarily ensure to the community the greatest dividends in service and benefits. In communities served by a reasonably large number of nurses a tuberculosis consultant nurse may devote profitably a portion of her time to the clinic. She not only should assume major responsibility in certain aspects of the clinic service but also should use the clinic for the guidance and instruction of the field nurses.

Can Work Better With Family

Every field nurse, even in the absence of a consulting nurse, should participate periodically in the clinic service for the benefit to patients whom she may refer to the clinic and also because of the contribution she may make in the appraisal of factors influencing the patient and members of his family. Because the behavior of tuberculosis is influenced frequently by environmental as well as constitutional factors, the public health nurse has much to contribute to the broad interpretation of a specific problem. The broader her knowledge and experience, the greater may be her contribution to the problem under consideration. The generalized public health nurse becomes more efficient because of this service. Through her knowledge of the many health, social and economic circumstances in the home she can help the clinician more adequately to appraise the problems that influence the health of the patient and the family and consequently is able more intelligently to assist in outlining a medico-social course of procedure.

The hospitalization of the newly discovered case of tuberculosis often presents a difficult and critical prob-

lem. Many of these patients will be in homes in which the public health nurse has already contributed to better family health. Because of her intimate knowledge of varied family conditions her influence should be considerably greater than that of the specialized nurse who will have no firsthand knowledge of the health, emotional and other characteristics of the members of the household.

Should this newly discovered patient reside in a home in which no previous public health nursing service has been rendered, the generalized nurse is often in the best position because of her day-by-day experience in dealing with the varied problems of family health to win the confidence of the family and influence a patient to accept hospitalization.

More Than One Problem to a Home

Unusual is the home in which only one kind of public health nursing problem exists. Accordingly, the visit of one specialized nurse after another creates confusion in the minds of the family, with the result that emphasis is often misplaced and the less important problem may receive first and greater attention. Moreover, as has been mentioned in every discussion of this subject, duplication of nursing visits is costly and time consuming and frequently deprives other families of this much needed service.

Keeping in mind the influence of environmental as well as constitutional factors, the home is frequently the first line of offense. Moreover, the death of the patient does not mean that the family problem is solved. The importance of education in personal hygiene, home hygiene and nutrition can hardly be over-emphasized. The incubation period of the next case may be a matter of years. In the meantime, other diseases and conditions may occur, which, if not dealt with appropriately, may be the very factors that result in the development of an additional tuberculosis case. Obviously, a nursing service equipped to deal with these other services is to be preferred.

While there may be socio-economic problems in meeting the needs of the discharged patient, the physical and prophylactic circumstances require the same broad fundamental nursing assistance as other cases. In

solving problems of a socio-economic nature it is necessary frequently to obtain the assistance of related health, welfare or industrial agencies and a well-directed, all inclusive, public health nursing service should have at least as good an entree to these agencies as a specialized service.

While every discussion of this question of generalized *versus* specialized nursing emphasizes the unsatisfactory situations created by having two, three or four nurses specializing in various diseases or problems visiting the same homes and the cost of such duplicate visits, little is said about the same problem as it relates to the private physician. Public health officials who fail to engender the sympathetic interest and participation of the practicing physicians in the public health program rarely produce optimum results. While it is generally conceded that the public health nurse acts as the liaison between the clinic, or hospital, and the patient and family, she can also act profitably in the same manner with respect to the physicians.

Can Enlist Aid of Local Doctors

The public health nurse is in a key position to enlist the cooperation of the practicing physicians. She can do this most effectively by being punctual in her appointments, brief in her discussions and flexible in her attitude.

Families may easily be confused or annoyed by multiple nurses' visits and a busy physician would react in the same manner. A generalized nurse presenting problems, in some of which a physician may have a genuine interest, may be much more successful in enlisting his aid in the public health program than two or three nurses who consume his time by discussing different types of problems discovered in the same home or homes.

While the generalized nurse may assist in the social rehabilitation of a patient, her service, because of its many connections with related or independent agencies, can enlist as effectively as a specialized nurse the assistance of such agencies as may be helpful. Here, again, multiple visits of different nurses regarding problems in certain homes are not conducive to efficiency.

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Relations With Local Governments

RECENTLY, a hospital administrator pointed out that the principal obstacle to good personnel relations in hospitals is lack of sufficient hospital income. "Our better employees, except that small heroic band whose devotion to its calling has held it steadfast, yield to the very natural allure of higher wages in industry and leave us dependent on the gleanings. We cannot compete in wages. We, therefore, ask our employees to make the philanthropic contributions. The situation is absurd.

"The remedy is obvious," he continued. "State and city and federal government must be called on to subsidize the hospitals during periods of national emergency. A method of subsidy can be devised so as to interfere in no way with the autonomy of the institution. There need be no implication of state medicine, no fear of political control. By means of an accurate presentation of the annual costs, income and deficit, based on existing methods of uniform accounting, subsidies could be allocated on the basis of free work rendered."

Rates for Indigents Are Low

In an endeavor to find out the extent to which small hospitals in various parts of the country receive payments from city, county and state governments, questionnaires were sent to 50 hospitals of fewer than 100 beds. Sixteen replies were received. While the number of replies is small, the geographic distribution is fairly wide as no state was represented by more than one reply.

Eleven of the 16 hospitals reported that they received some payment for the care of indigent patients from city, county or state funds. The rates of payment ranged from \$4 per day in New York State to \$2.10 per day in North Dakota. One receives \$2.15 per day plus extras at 50 per cent of regular rates; two others receive \$2.50

per day, one of them also getting up to 50 cents per day additional for drugs and the other receiving \$5 extra for a major anesthetic. One hospital receives \$3. One is paid regular rates by the county, another receives ward rates to a maximum of \$3 daily and a third receives 50 per cent of regular rates from one county and 75 per cent from another. Three hospitals did not answer and two stated that they receive nothing at all.

In the entire group, only one hospital receives more than \$3. If the hospital were dependent entirely upon this income, it is obvious that salaries could not be high.

The second question referred to payments for workmen's compensation cases. When governmental units pay for the care of these patients, they are more liberal than they are for the care of the indigent. However, only nine of the 16 hospitals reported any payments at all and one other stated that it was paid "very little." Two receive the regular rates. One receives \$3 per day; two receive \$3.50; one receives \$3.25 plus extras, and one, \$4.50.

As regards the crippled, seven hospitals receive nothing whatsoever for their care. Other amounts received are: \$2.10; \$2.50; \$2.50 plus \$1 from the Duke Endowment; \$3; regular rates (two hospitals); substantial state subsidy to support a large department, and payments according to a state schedule. One hospital is paid for x-ray service only.

Eleven hospitals report no pay whatever for the care of automobile accident cases. Three hospitals are paid at regular rates if the victims are indigent; one receives \$3.10 for ward cases and \$4.10 for private cases while another receives \$4 per day.

One hospital also mentioned that the state pays it for the care of afflicted patients, mostly children, but did not mention the rate of payment.

The hospitals were asked whether the payments by state and local government are based on actual cost to the hospital or are merely arbitrary amounts. Ten institutions reported that the rates were set without any particular relation to cost. Five reported that regular rates were always paid and that they tried to keep their regular rates in line with costs. In Mississippi, apparently, the rate is determined on the basis of 15 cents per capita for the population served.

"What control do the city, county and state governments exercise over the quality of service rendered to these patients?" No control at all is evident in 11 of the reporting hospitals. In Texas the social welfare agents and city and county commissioners exercise some control through their appointment of city and county doctors. The Mississippi Hospital Commission has set up minimum standards for hospitals in that state receiving state aid. In New York State there is an annual inspection by the department of social welfare.

All of those that reported some control thought that it was beneficial, except the New York hospitals which considered it unnecessary.

How Improve the Situation?

In spite of the inadequacy of the payments to hospitals, 10 of the 16 hospitals replying had nothing to suggest to improve the situation. The comments of the other six were: hospital education of local government officials (Texas); state laws inadequate because too much authority is given to county commissioners (Montana); local government should pay part of the cost of the care of the indigent (Mississippi); all aspects of hospital care of the indigent should be divorced from local government (North Carolina); arrangements satisfactory (New York), and county is reluctant to approve bills for care of accident cases (Michigan).

Thus, the one state in which the local government has nothing to do with the problem wants more local participation, while most of the states that have local responsibility (in full or in part) want to center the responsibility on the state.

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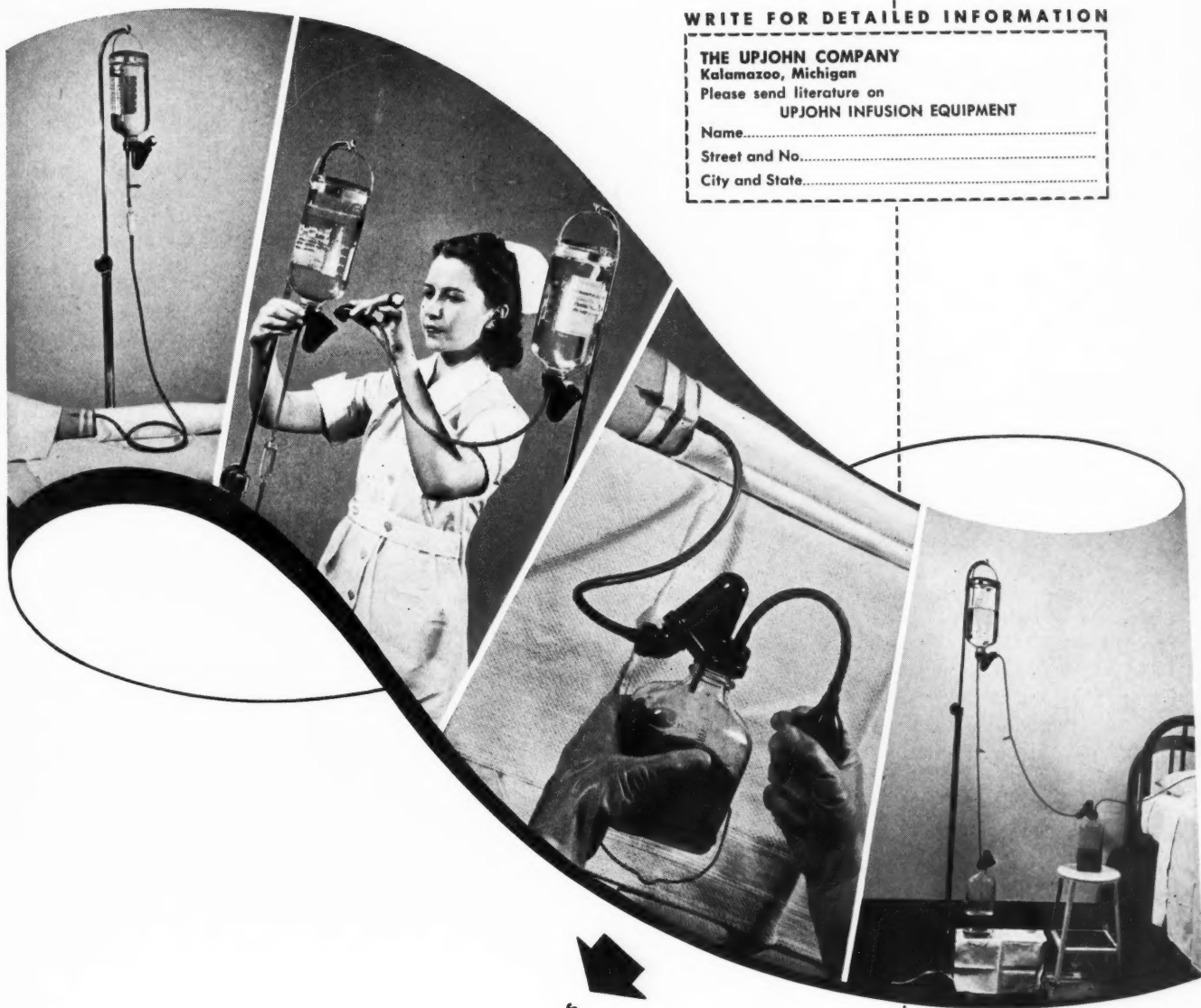
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WOMEN'S SERVICE GROUPS

Mrs. Schiller's Hints to Volunteers

Hints to hospital volunteers, as worked out by Mrs. William A. Schiller, whose enterprise at New York Post Graduate Medical School and Hospital has made her conspicuous in the field of women's auxiliaries, are worth passing on to all service group members everywhere. Here they are:

1. *Exercise the utmost tact in your dealings with the staff.* Suppose a nurse asks you to tell a nurses' aide to give a patient another blanket; be careful not to let it appear that you are giving the order for that will cause resentment.

2. *Never take unto yourself privileges denied to staff workers.* If you use much makeup and bright nail polish, you will be considered as someone apart.

3. *No matter how much praise you receive, never let it go to your head.* Never become officious. More volunteers go wrong through becoming self-important than from any other cause. Modesty is the volunteer's most charming attribute.

4. *Never criticize the hospital or its clinic administration or express any opinion in connection with diagnosis or treatment.*

5. *Never discuss with outsiders any secretive details of hospital work.*

6. *In dealing with patients, be courteous, interested and cheerful.* If you display sympathy, be sure that it is of an impersonal nature. You will find excellent examples of kind, impersonal sympathy if you observe the nurses and social workers in their dealings with patients.

7. *Be guarded in any advice you may give, as patients may mistake you*

for a nurse since you wear a uniform. You don't want your words to be taken as those of someone in authority.

8. *In taking case histories or in talking with patients, keep your voice lowered.* You are discussing their private affairs.

9. *Confine your conversation with doctors and nurses, as far as possible, to professional subjects.*

10. *Follow strictly all instructions from doctors and nurses.* If a doctor says black is white then, so far as you are concerned, black is white.

11. *Refer all questions of doubt to the nurse or social worker under whom you serve.* It is far better to interrupt than to make a possible mistake.

12. *Never repeat to a patient what the doctor has said.* The patient may try to wring this information from you, but be firm!

13. *Never give visitors specific information about a patient's condition.* If the visitor is persistent, refer her to the nurse in charge.

14. *Never give information about one patient to another.* There might be one exception to this rule. If you know a patient is worrying about an operation that is to be performed, you might say: "The patient in 910 had that operation and is feeling fine again." Note that you do not mention the name of the patient in 910.

15. *Never let a patient see his chart.* Do not place the chart on the bedside table. When escorting him for discharge, your hands may be full of suitcases, flowers, boxes, topcoat, discharge book and chart; nevertheless, use your ingenuity and do not let him carry the chart.

Thirty-Seven Years of Service

Thirty-seven years of service is the record of the auxiliary of the New Jersey Orthopaedic Hospital and Dispensary, Orange, N. J., with two of its original volunteers among the 50 active and 25 associate members who are today rendering valuable assistance in practically every department.

This information comes from Mrs. G. W. Morris Jr., corresponding secretary, who explains that because the Orthopaedic is small (26 ward beds and 8 semiprivate beds) numerous home-like touches are possible and these the auxiliary gladly provides. It keeps window boxes filled summer and winter with flowers and greens and provides flowers for the entrance hall.

Each patient spending a birthday in the hospital is given a birthday cake and at Christmas there are trees, wreaths and other decorations with gifts individually selected for each adult and child patient as well as for the personnel.

Among the major duties assumed by the auxiliary are registering patients at the clinic desk; acting as aides to clinic nurses, in the physical therapy and diversional therapy departments and in the plaster room, and serving as hostesses to guide visitors and new patients. Two groups meet each week during the winter to make surgical dressings, while other members assist in the distribution of magazines and books from the hospital library to the patients.

Perhaps the most spectacular activity, however, is the "Cafe Chantant," an evening's entertainment with vaudeville and refreshments, followed by general dancing in a gaily decorated auditorium. This generally nets about \$3000, which goes in part to the support of the Children's Country Home in Westfield.

Incidentally, the committee responsible for the Cafe Chantant has 100 collapsible tables made slightly smaller and sturdier than ordinary card tables, which it rents to other organizations giving benefit performances. This provides an additional source of income.

Three Projects That Appeal

Three special funds are maintained by the hard-working women's auxiliary of Touro Infirmary, New Orleans. Membership dues go into the general fund and take care of expenses and even build up a substantial reserve. But these special funds come from the women's activities and a busier bunch of women would be hard to find.

Take, for example, the Tuberculosis Clinic Fund. The usual run of readings, style shows, rummage sales, bazaars and card parties helps maintain it. Another source of income is from the Happy Day and Memorial funds to which members and friends are urged to contribute rather than giving birthday or anniversary presents or sending flowers to funerals. Happy Day and Memorial contributions go to the pneumothorax clinic to provide x-ray examinations and pneumothorax treatments for the indigent.

The Insulin Fund was started by the wife of a diabetic patient who came to the hospital to learn how to give her husband injections. So grateful and impressed was she that she started a fund to buy insulin for those who could not afford to buy it themselves. Auxiliary members solicit donations from the community to maintain this fund.

The Fund for Cripples is built up from proceeds of the sales of homemade sandwiches and cakes in the hospital coffee shop, sales of flowers in suitable containers in the hospital lobby, and sales of old gold, silver and tin foil. The money buys braces and other appliances for orthopedic patients, who are expected to repay the cost of the equipment in small monthly payments. Eighty per cent of the patients thus aided have repaid the entire cost of such appliances, it is reported.

This is the work done by the three funds only. Some day we must ask Mrs. Herman L. Barnett to tell us of the work done by the various Touro committees.



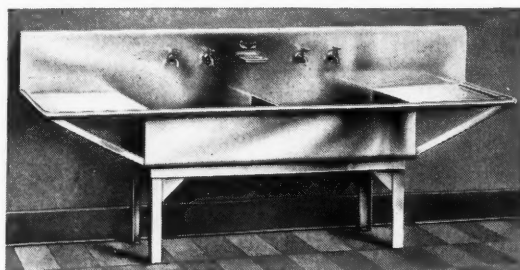
Only HEALTHY MEN

Can FIGHT!

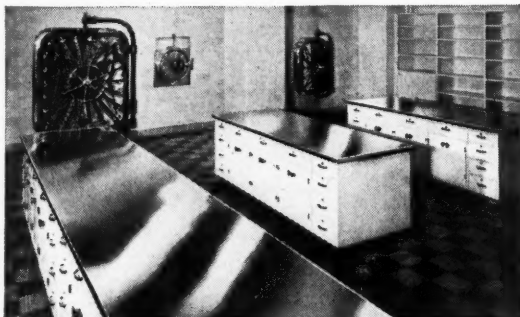
—and, it makes no difference whether these men are at the front, in the air, at sea, or working in factories and shops producing essential war supplies and equipment—they are ALL engaged in a desperate FIGHT to win this War!



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COOPERATION WILL WIN THIS WAR

England Learns From War

CHARLES HILL, M.D.

Deputy Secretary, British Medical Association

HOSPITAL and medical service in England is being critically reviewed in the light of war conditions, for war is a testing time of organizations as well as of individuals. War-time problems have de-

manded war-time remedies and, if experience is our guide, war-time remedies do not always die with the peace treaty.

Few will assert that the postwar era will see a return to prewar con-

ditions. Cooperation, coordination, regionalization, call it what you will, has come to stay. War has its tragedies but this may prove to be one of its triumphs. To translate the temporary organizations of war into the permanent structures of peace has become the goal of the Medical Planning Commission, a body of some seventy well-known doctors representing all branches of medical practice and all parts of the United Kingdom. The commission is now hard at work preparing to face the problems of reconstruction in the field of medicine.

Before the war the hospitals of the country were organized in two main systems, distinct and often unrelated. On the one hand, we had the voluntary hospitals rich in historic traditions and outstanding in the quality of their service; on the other, the state hospital service of recent but very rapid growth. Cooperation was the theme of hospital reformists, but it took a war to make it a fact.

All the hospitals of the country, voluntary and state, have been welded into one large national service, grouped into regions, each with a government officer virtually in charge. Patients are referred to one or another hospital according to their individual medical need, regardless of their financial standing.

Twenty million wage earners enjoy the benefits of a national health insurance scheme but their dependents do not. There is a growing demand that the state should organize a medical service for the wives and children no less than for the wage earners themselves. The middle classes, hitherto able to obtain the medical services they needed on a fee-paying basis, are contributing a large slice of their incomes to the war effort. They now need not state aid, but organized insurance provision. In this way an annual premium will replace the doctor's bill. Such insurance schemes, started in many places



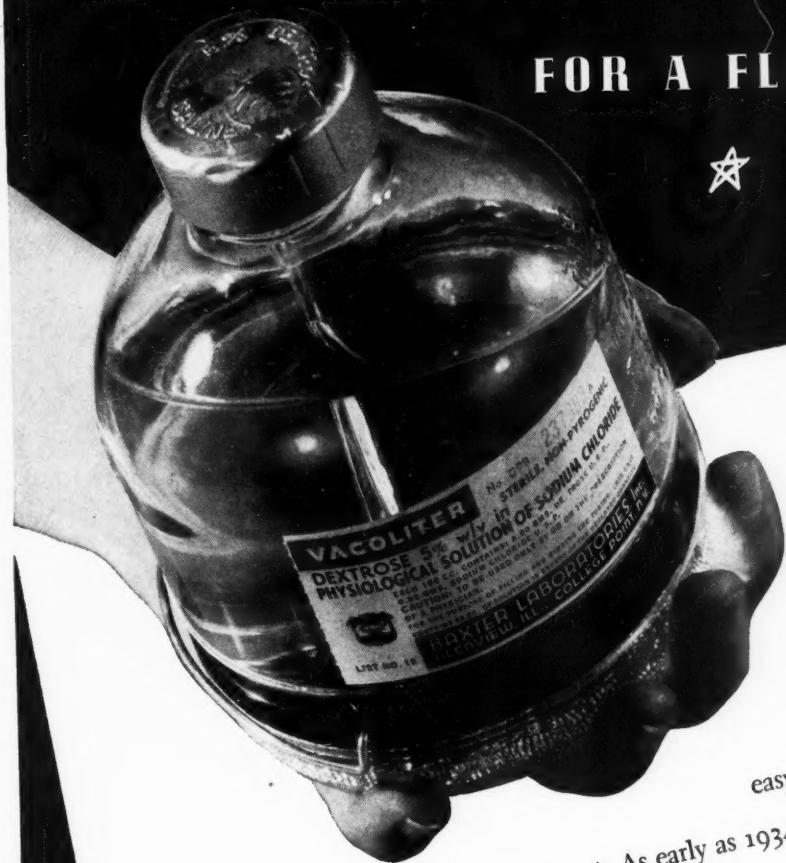
British Press Service

●MEET J. W. KIBBLE of the British Marines, who spent thirty-one days in an open boat after having been torpedoed in the South Atlantic. Kibble and his 30 companions eventually were picked up by a Dutch boat 450 miles from land. His ears were badly damaged by the explosion of the torpedo. In spite of this handicap and the frost bite he had contracted, Kibble worked his way back to England as the gun layer of another Dutch boat. Here he is having his ear dressed in one of the emergency hospitals of the British Ministry of Health where air raid casualties, civilian defense forces, evacuated children, the land army and men in the armed forces are treated. The hospital shown here is one of the many base hospitals in country areas to which city patients are transferred. This one story hospital is especially built for the purpose, being of the semipermanent type of construction.

Milestones in **2** Medical History
1934

THE *Baxter* HALF-VACOLITER

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before the war, will need to be organized on a wider and, possibly, on a national basis after the war.

In general practice no less than in hospital practice the war has compelled a higher degree of cooperation. The work of the doctors who have joined His Majesty's Forces is being undertaken by their colleagues as a team. Incidentally, the remaining doctors do the work of absentees for half fees, passing the other half

to the serving doctors. Fewer doctors means a heavier burden of work and this of itself has induced cooperation between groups of teams to a degree never before equaled in this country. The war has accentuated the prewar tendency to cooperative or group medicine.

The Medical Planning Commission recognizes this trend and it is no secret that it is contemplating proposals for the organization of general

practice on a group basis, with the local health center as its focus. At such a health center will be provided the primary medical service needed by the local community. Both preventive and treatment services will be available under the one roof by the one coordinated team of doctors using the communal equipment and enjoying the stimulus of mutual association and friendly criticism.

Will the fee paying method continue? Will the doctor be paid when his patient is ill in proportion to the nature and length of that illness? There is a growing feeling in Britain that this practice should, at least for a large section of the community, disappear.

Already the 20,000,000 persons covered by national health insurance enjoy a general practitioner service on an insurance basis. The insured person contributes, the employer contributes and the state makes a small addition. The abolition of the fee does not necessarily involve placing the medical profession on a whole-time salaried basis under the state. It does not necessarily mean an interference between the personal relations of doctor and patient. But, provided the doctor is adequately paid for his work, his payment need not come from the patient in his time of distress.

Change Is in the Air

It is still too early to prophesy what proposals the Medical Planning Commission will place before the legislature. It is clear, however, that the impulse toward an increased state responsibility for medical care, toward the removal of any impediment, financial and other, that may stand between the patient and the medical service he needs, grows stronger every day in both medical and lay circles.

Uncoordinated and unrelated services will be absorbed in a comprehensive service linking hospitals, general and specialized, with the district and local health centers. Change is in the air and the medical profession is preparing so that it may be ready to meet its responsibilities in a world in which many values will be changed, in which newer conceptions of society will be formed and in which new remedies for old problems will appear in the democracy that is our heritage.

Meeting the Test of War

GEORGE P. ETTENHEIM

President, Mount Sinai Hospital, Milwaukee

WAR TIMES test the character and capacity of men and women who are delegated to perform a public function. War times call for longer hours, economy, patience, earnestness of design, a spirit of real cooperation and a concentration of all possible human effort toward a common goal.

What, then, is or will be required of us and our hospital?

The preference ratings afforded hospitals cannot and should not be abused. Without health no nation can succeed, and our government realizes the need of satisfying our requirements for materials. We should bear in mind that every inch or ounce of supplies wasted is, in fact, a treasonable and unconscionable act.

Naturally, the cost of food, labor and every commodity has increased. And the end or peak is not in sight, by any means. Stabilization of costs is impossible.

Our hospital and all the other hospitals will be justified in providing for increased charges in all departments; not only is this justified but it is imperative in order to meet rising costs of operation. We can partially meet these problems by a policy of conservation and economy, by watching each step with a view toward saving all we can. Such is nothing more than sound business dictates.

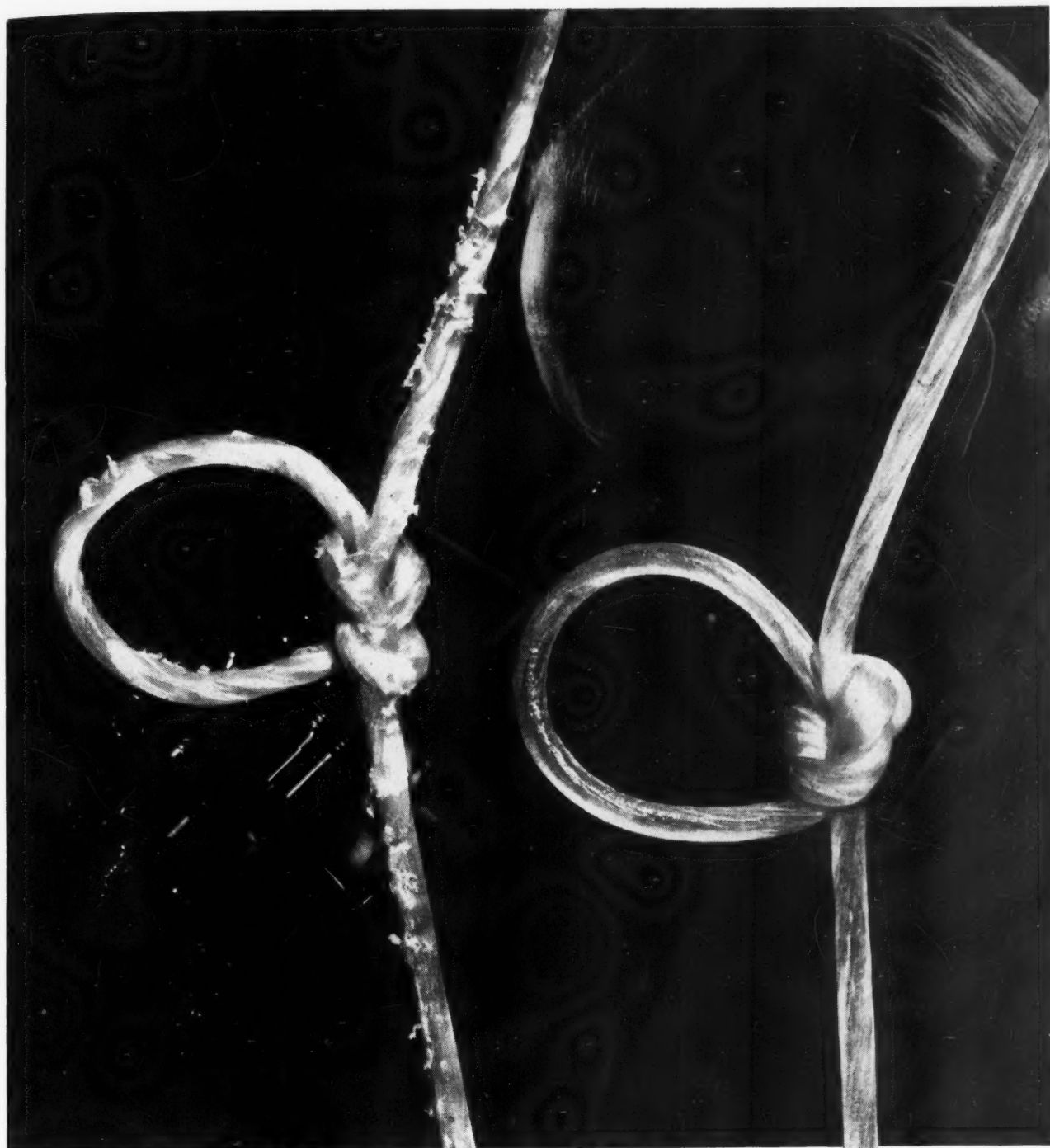
Of course, personnel will be affected by the call to active duty of doctors, nurses and technicians. Substitutes, well meaning as they are, will be less skillful but they must be

accepted with patience and understanding. And if places cannot be filled, those remaining must double and redouble their efforts to do part of the absentee's work. This is the spirit we expect; it is the spirit to which we are entitled in times of national emergency.

There will undoubtedly arise limitations upon the field of research and the extent of nursing education. Efficiency should not be reduced; intensity of work must make up for deficiencies arising through circumstances beyond our control.

We may be called upon to assist in the rehabilitation of men rejected for service or recovering from injuries in the course of service, to help train nurses for special field work and to perform war-time functions. We cannot turn away from such calls. Everyone must answer the summons to service gladly and with determination to do better and more work than he or she ever did in time of peace.

The census of local hospitals indicates that hospital facilities are at present entirely inadequate. It is impossible to find the reason for this unusual rise in hospital attendance. Whether it is the enormous expansion of defense industries, the hospital service plans, the hospitalization of those who, now earning higher wages, have finally decided to attend to their long-neglected medical needs, no one seems to know. Be that as it may, the public, too, must realize the impossibility, under crowded conditions and other serious handicaps, of hospital care as usual.



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Sanitation Comes First in Manufacturing Ice

SIDNEY M. BERGMAN

Superintendent, Sinai Hospital of Baltimore

CRUSHED ice is an important adjunct in caring for patients. It is required for cooling beverages, for chilling foods. It is used in ice collars and ice packs and is required for cooling the oxygen used in tents.

We are particularly concerned here with crushed ice used in relation to food and beverages. If we trace the ice from its production source to the patient in our institutions, we are likely to find that it travels under conditions that may well give us cause for concern. Some years ago, in a well-run hospital, the bacteriologist collected samples of ice from drinking water in pitchers at the bedside of patients of the institution and, out of 12 samples, found two from which colon bacilli were cultured.

Not uncommonly, the method of crushing ice is as follows:

An employe, usually designated as the iceman, draws 100 pound blocks that have been frozen in galvanized tanks in the hospital ice room. These tanks are usually not provided with the agitation method required in commercial plants nor are the tanks sterilized. The ice, when drawn, is conveyed to the ice crusher, usually mounted on the concrete floor of the ice room. The ice is broken into small chunks with an ice axe and the chunks are thrown into the crusher, usually by hand. The crusher probably delivers the crushed ice in a heap on the floor, from which it is shoveled into pails by the iceman.

The floor on which these operations are performed obviously has been walked on by the iceman who, in his peregrinations through the hospital, has traversed areas subject to many forms of contamination. The ice in pails is brought to the main kitchen, to the diet kitchens on the floors and to the utility rooms.

Almost the entire manufacturing cycle is represented in the picture at right showing the interior of the insulated ice chest. The newly manufactured flaked ice drops from the opening above the bin from which it is dispensed through the chute into a waiting pail.



Too often, ice used for utility purposes and for food and beverages is kept in the same place. This practice is particularly unfortunate, since it is not an uncommon thing to find a nurse filling an ice collar from the chest containing the dietary ice.

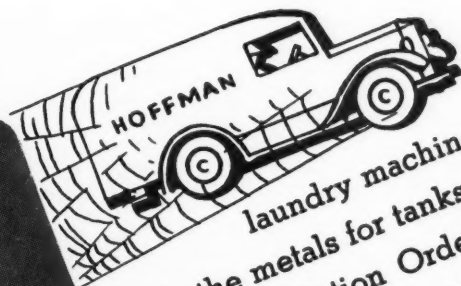
With a view to improving this situation, Sinai Hospital of Baltimore recently installed three electrically cooled units for manufacturing ice from water as it comes directly from the water supply system. These units provide a means by which the water flows in a thin sheet over a slowly revolving metal drum with an extremely cold surface. The water freezes on contact into a thin sheet of ice. It is discharged by the rotating motion through a chute in a cascade of thin flakes, pure as the water supply itself.

Starting with this supply of pure flaked ice, it occurred to us that if the ice could be received in a sanitary metal bin properly insulated and provided with a chute through which the ice could be dispensed without coming in contact with human hands or other source of contamination, the situation would approach the ideal. Therefore, a large ice chest was constructed with oak double walls and insulated with 4 inches of cork. The interior was lined with sheets of galvanized iron.

The ice machines are arranged in a row so that their chutes deposit a constant stream of ice flakes into the metal bin below. The bottom of the bin is built sufficiently high above the floor to permit an ice pail to be placed directly under the chute at one end of the bin; when the door

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of the chute is open, flake ice can be raked directly from the chute into the pail. For this purpose, a special rake has been made. It consists of a flat piece of wood fastened at right angles to a wooden pole.

The ice chest containing the bin is sufficiently large to permit the iceman to walk into it and close the door. An electric light in the ceiling of the box provides illumination. The iceman conveys the ice so col-

lected in pails to the various parts of the hospital on a large platform truck, which permits distribution of ice to the whole hospital in two trips. When the ice reaches the diet kitchen or utility room, it is poured from the pail into an insulated ice container. A metal scoop is kept in the ice container for the convenience of the person obtaining the ice.

In dismantling our old ice room and eliminating the freezing tank,

which contained 20 galvanized tanks, we were able to salvage sufficient cork insulation to build a new ice box. All the labor involved was performed by the hospital maintenance department under the supervision of the chief engineer.

The initial cost of the new installation was much less than that of an ammonia plant of the same capacity and the expense of operation has proved much less.

Engineers' Question Box

Washing Walls

Question 18: Should walls be washed from the bottom up or from the top down?—H.A.C., Mo.

ANSWER: This is a debatable question. Which method is employed depends on how careful and thorough your wallwasher is. There is always danger from spotting if the walls are washed from the top down when the wallwasher is using a sponge. If he is using a wallwashing machine that has a control valve on the paddle so as to control the saturation of the towel used, then the danger of spotting can be eliminated by an efficient and careful operator.

Washing walls from the bottom up, whether you are using sponges, towels or a wallwashing machine, is by far the safer practice, because once a dirty wall is spotted by the soap solution it is almost impossible to remove the spots without leaving marks on the surface.—LELAND J. MAMER.

Central or Unit Refrigeration

Question 21: What are the relative advantages of central and individual refrigeration systems?—S.E.J., Tex.

ANSWER 1.—The advantages of the individual refrigeration system over the central refrigerating system are as follows:

1. Greater flexibility.
2. Each unit reacts to its particular demand immediately.
3. The multiplicity of sizes and types fits every conceivable application.
4. Additions can be made piecemeal and only as needed; remote locations are not dependent on a long pipe run causing line losses.

Small groups of refrigerators on one central machine have been found exceedingly practical when all have a similar duty and nearly the same tem-

perature requirements, such as those of a main kitchen group or a group of storage rooms. Four or five boxes grouped on one machine does away with the necessity for long runs of refrigerant mains. This type of setup would thus consist of three or four machines of equal size to make for ease in servicing, maintenance and replacement of parts and interchanging of load if one machine should fail in an emergency.—JOHN A. DOHERTY.

ANSWER 2.—It is an advantage, especially for hospitals of the larger size, to have central refrigerating plants. The operation is more economical; care and maintenance are centralized, and the life of the equipment will outlast that of the smaller individual units by many times.

Individual units are practical in the smaller hospitals where there is generally a lack of skilled labor and also whenever additional equipment is

needed in a location too far from the central refrigerating plant.—JOHN H. HERZOG.

ANSWER 3.—The advantage of central refrigeration systems is central control over the whole system, a distinct advantage in defrosting and other operations of the system, since it saves the labor of someone's going to individual boxes.

Individual refrigeration systems have the following advantages: (1) repair of separate units without having to shut down the entire system; (2) elimination of extensive circulation pipe lines requiring considerable maintenance; (3) reduction of the electric power peak loads and the necessary costly maintenance of a large machine; (4) saving of considerable space required for a large central machine; (5) saving of costly valves, piping and automatic appliances required for a large central machine.—WILLIAM J. MOMBERGER.

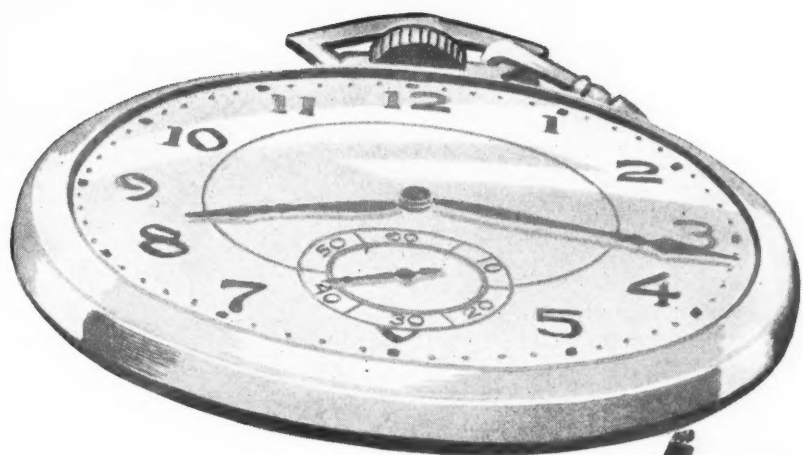
Wet Dressings Answer Voted Best

Edward Silverman, assistant engineer, Mount Sinai Hospital, Philadelphia, is \$5 richer because of submitting an answer on how to avoid wet dressings in the sterilizer. The same question was answered quite differently in an earlier issue of the magazine but the judges preferred Mr. Silverman's ideas as they appeared in the July issue.

The effects of priorities and rationing on hospitals are reflected in the questions published this month. We must all cooperate fully in meeting this situation. If you have some good ideas on substitutions or conservation, why don't you sit down now and send them in? Others will do the same and all hospitals will benefit. Furthermore, we shall be helping in the nation's effort.

Here are the questions to start off your thinking:

37. How can we preserve the metal of our air washer pans in the ventilating system?—A.C., Mo.
38. What must we do to lengthen the life of the rubber belts on various pieces of hospital equipment?—W.D., Ill.
39. In view of the rubber shortage, I am worried about replacing the dump valves on our laundry washers. Is there anything I can use in place of rubber?—R.C., Ark.
40. Is it safe to use valves on the brine lines of our refrigerating system if the body and trim of these valves are of iron?—M.A., Ont.



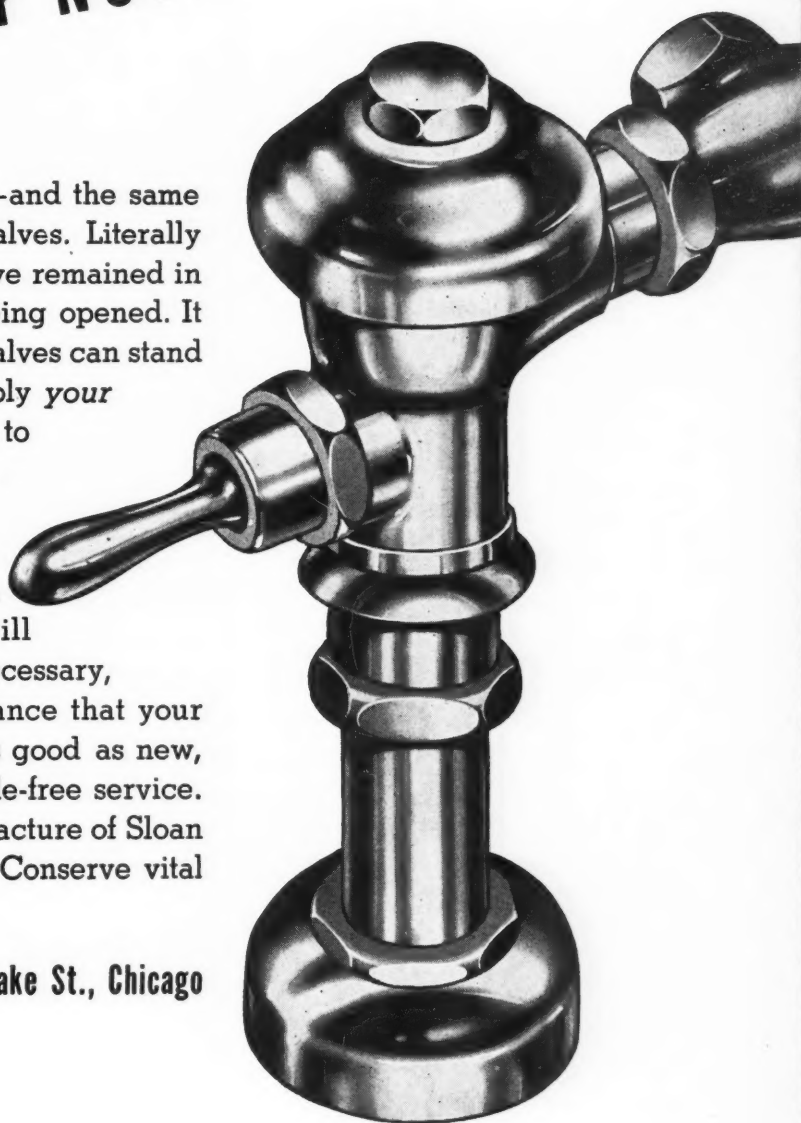
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Selecting Fabrics

Four important considerations that should be kept in mind in purchasing curtain, drapery and slip cover fabrics are: (1) color-fastness and washability; (2) crisp "handle" and permanent finish; (3) eye value, and (4) durability. The following suggestions issued by a textile firm should be helpful in making selections:

1. *Color-Fastness and Washability:* Be sure that all goods purchased for curtains, draperies, slip covers and bedspreads are guaranteed color-fast to both sun and water. At the time the order is placed obtain proper washing instructions from the manufacturer.

2. *Crisp Handle and Permanent Finish:* One cannot always determine from the handle of a cloth whether it will retain its crisp new feeling after laundering or cleaning. However, one trip to the laundry or even a protracted period of damp weather will disillusion the most enthusiastic buyer when she finds that her draperies are beginning to look limp and wilted.

3. *Eye Value:* Patients' rooms should be cheerful but restful, never somber or dull. Solariums and public rooms may be furnished with gayer colors and more definite designs than are used in patients' rooms.

4. *Durability:* It is generally agreed that hospital furnishings receive harder wear than do any other types of interiors. Perhaps the necessity for extreme cleanliness resulting in frequent cleaning and washing is responsible for some of this additional wear. Therefore, it is imperative to use fabrics that can be expected to render unusually long service. Materials that can stand just the average amount of wear will not be entirely satisfactory for hospital use.

Keeping Employees Contented

"We try in every way to establish a feeling of unity and confidence in the management among our employees," reports Althea C. Berry, executive housekeeper of Albany Hospital, Albany, N. Y.

"A visit to the sick and a word of assurance that their jobs are waiting for them often help to speed their recovery. All our employees are entitled to free hospitalization when they are ill. Before anyone is hired in any department a careful physical examination is given. This, of course, weeds

out all of the physically undesirables and greatly reduces the turnover in personnel.

"Do you realize how expensive employee turnover is in any institution? It is estimated that the equivalent of one week's pay is wasted before any new employee is well broken in. Loss of time in teaching, loss of speed while learning new methods and waste of materials are some of the problems that a department head should consider before she makes a change among her workers."

Beauty Hints for Mops

There is a right way and a wrong way to clean a yarn mop, as there is everything else. It is suggested that the water should be boiling hot so it will cut the grease and dirt. If by chance a steam boiler is available, run a small

steam line from the boiler into a 15 gallon oil drum, about 8 inches from the bottom of the drum. Next a piece of hail screen should be fitted in the drum and put on legs to keep it about 6 inches from the bottom so that the mops will not lie in the dirt. The drum is then filled about three fourths full of water and $\frac{1}{4}$ pound of cleaning powder and $\frac{1}{2}$ pint of neutral soap are added. The mops are then put in and the steam turned on lightly.

The mops should be stirred around several times and kept in until clean. When ready to come out, one at a time they are put into a wringer scrub bucket partly filled with clean water, after which they are hung up to dry.

Try This on Cockroaches

From Brazil comes this formula for getting rid of cockroaches—a method that is said to be as successful as it is simple.

"Mix equal parts of boric acid and powdered sugar; sprinkle around baseboards and other favorite hiding places of roaches. In a few hours they will all be gone."

Removing Linen Stains

The hospital laundry is frequently called upon to identify stains and to clean fabrics that have been so stained. These stains present a problem that is not usually encountered by the commercial laundry and special methods

are frequently required to eradicate them.

The accompanying list was compiled by A. Martin, laundry foreman of Touro Infirmary, New Orleans, after repeated experimentation and testing of various methods of cleaning.

Removal of Stains

STAIN	IDENTIFICATION	METHOD OF ERADICATING
Methylene blue	Blue color	Immerse fabric in warm water. Soak in hot stripper or 1 ounce per pint of water (sodium hydrosulphite), then launder as usual.
Iodine	Color and odor	1 ounce of sodium thiosulphate to a pint of water.
Merthiolate	Yellow color	Soak in very hot water and then use any stripper solution. Wash in usual way.
Argyrol	Brown or black color	Soak in sodium thiosulphate (2 ounces to a pint of warm water and 2 tablespoons of ammonia). Wash in usual way.
Silver Nitrate	Black color, usually darker than argyrol	2 ounces of sodium thiosulphate to pint of warm water. Soak in water containing 2 tablespoons of strong ammonia to pint of warm water. Wash in usual way.
Mercurochrome	Brown color	Work stained linen in 2 per cent solution of potassium permanganate at from 100° to 130°F. for a few minutes; then rinse in 2 per cent solution of oxalic acid, at the same temperature until all brown discoloration is gone. Wash in usual way.
Medicine and Salves		Keep in hot soap solution until stain is removed.
Blood		Put all bloodstained linens in water at once until stain is removed; then send to laundry.

HAWAII STILL SENDS ITS FINEST

Hawaii, in spite of being in what might be called a war zone, under martial law, with all its problems of transportation, labor, and nightly blackouts, still produces the world's finest pineapples.

There has been no report of war damage to the plantations or the cannery of the Hawaiian Pineapple Company.

Dole growing and canning operations are scheduled at the maximum level consistent with offensive and defensive war plans in the Islands.

If the Pacific situation does not change materially, it is expected that the movement of the 1942 pack to the mainland will not be a great problem. Grocers, however, may receive the new pack later than normally because of the necessity of first providing for government requirements.

The government's request for the armed forces will take about one out of every three cans of Hawaiian pineapple and about one out of every five cans of Hawaiian pineapple juice. This,

plus the influence of an early season drought on the 1942 pack, means that the amount of Hawaiian pineapple available for mainland consumption will be materially reduced this year.

The Hawaiian Pineapple Company will make every attempt to secure a just and equitable distribution of all Dole Pineapple and Dole Pineapple Juice available to the mainland.

The nutritional influence of Hawaiian pineapple products will continue to be emphasized in Dole advertising in national magazines. The vitamin B₁ and vitamin C content are such that the products are rated a "good to excellent" source. Advertising carries the Seal of Acceptance of the Council on Foods and Nutrition of the American Medical Association.

Long May Our Equipment Live

MABELLE S. EHLERS

Professor and Head of Institution Administration
Michigan State College, East Lansing

THE institution that needs equipment today is in a sorry predicament, since the possibility of finding a dealer who happens to have a few pieces on hand is remote. Those individuals who were farsighted enough to replace worn-out articles with new while they were still available have a problem, too, for no one knows how long the present situation will continue and even new equipment does not last forever. Postponing the evil day when present equipment will be no longer usable is of paramount importance.

The life of any equipment can be prolonged by proper care. This involves a personnel problem. One must have employees who understand the care of equipment or who have intelligence enough to be taught how to care for it. Someone in the institution must have the time not only to instruct the employees but to check often enough to make sure that instructions are being followed. Hence, assuring the proper care of equipment becomes a large order.

Labor Shortage Is Factor

Many institutions are faced with a labor shortage. At a recent meeting in Michigan, more than one dietitian told of having to stand over the range helping to prepare meals or over the sink washing pots and pans. In such a situation, it is evident that equipment is not likely to receive ordinarily good care, let alone special treatment. However, it may be well to indicate what should be done if, when and as possible.

Oiling should be mentioned first. It has been said that women do not appreciate machinery and that one of their shortcomings is failure to keep it oiled. The first step in the campaign to conserve equipment, then, might well be the examination

of every piece that has moving parts. There is bound to be friction where there is movement of one part over another and unless there is lubrication of these parts sooner or later there is wearing away of the metal with eventual failure of functioning.

If oil holes can be found, well and good; they were put there for a purpose. If no oil holes can be found oil should be put on any part that moves. If a maintenance man is available ask him what parts of the various pieces should be oiled and have him show you how to do it. He soon may be going into service so it is a good idea to learn from him while you still have him. If no maintenance man is available, consult the man from whom the equipment was bought or the manufacturer.

Next comes cleanliness. "Keep it dry and clean" should be the basic direction for caring for almost any type of equipment.

Some utility companies will send a man at stated intervals to check gas or electric pieces, usually charging by the month for such services. He will replace worn parts if new ones are still available; he will check thermostats to see that they are functioning, and he will clean flues. It is important that carbon be removed since it acts as an insulator and thus wastes heat. Here is another job for the maintenance man.

Care of Specific Pieces

Some suggestions follow for the care of specific pieces of equipment:

Bake Ovens and Ranges.—All petcocks and burners should be checked by the local utility company. The leakage of gas should be guarded against as it is dangerous as well as expensive. The interiors of ovens should be cleaned after each use. Burned pie fillings on the floor of

the oven turn to carbon and this carbon will act as insulation. Oven door hinges should be kept clean. They should be replaced when worn. The exteriors of ovens and ranges should be painted every six months.

Gas burners can usually be removed for cleaning. If there have been spill-overs so that the ports are stopped, they can be freed with a pin or wire or with that famous implement the hairpin.

Dishwashing Machines.—The oiling of these machines is particularly important. They should be de-limed frequently but carefully. If acid is used, followed by scraping, the acid sometimes eats through the lime deposit into the metal and the scraping may break the surface of the metal. If this happens, rusting will result if the body of the machine is built of galvanized iron. Rusting is eventually followed by holes.

A good powder should be used for dishwashing purposes. If it contains material that prevents the formation of lime, the danger of harm to the machine from lime removal methods will be obviated. After using, dishwashing machines should be dried with cloths. In actual practice, this is seldom done but it does lengthen the life of the machine.

Dish Tables.—If the tables are of galvanized iron, they should be dried with a cloth after use. The pipe standard or angle iron legs should be repainted every six months. If there are any loose parts, they should be soldered to prevent corrosion. If the dish tables are of stainless steel, little maintenance is needed except that any loose corners or cracks should be soldered.

Mixers.—Motors and gears should be greased and oiled regularly. Defective parts should be replaced if new parts are available; otherwise the machines should not be used. Hand mixing can be done, provided

the necessary help is available. The bowls should be kept dry. Whips should be tightened and rewound if necessary. The machine itself should be repainted if it shows signs of rusting. Employees using mixers should be reminded that they should be started at slow speed.

Food Choppers and Grinders.—The motors should be greased and oiled regularly. The revolving bowl or receiving chamber should be washed and dried thoroughly after every operation. When grinding or chopping meat, care should be taken to see that the meat is free from bones. Bones are likely to break the knives in grinders and dull and sometimes break the knives in choppers.

Meat Slicers.—These pieces should be cared for in the same manner as the choppers.

Potato Peelers.—The motors should be greased and oiled. The machines should be cleaned and thoroughly dried after each operation. A steam hose is excellent for cleaning potato peelers. If the revolving disk is worn so that the machine does not function well, it should be replaced. Even the cylinder can be replaced, provided the dealer still can obtain new ones. The peeler body should be repainted if it shows signs of rusting. Peelers should not be overloaded as an overload is hard both on the potatoes and on the machine.

Cook's Tables.—If the cook's table has a wood top, it should be scrubbed clean once a day with a brush, soap and detergent, rinsed with clean water and dried. Moisture allowed to stand on the top has a tendency to crack it. Cutting should not be done directly on the table top, but if this has been done and the top is worn as a result it can be made smooth with a plane. Cutting boards are inexpensive and will save the table. If the legs of the table are of galvanized iron they should be kept painted as should the utensil rack.

Counters.—If the exterior of the counter is painted, it should be repainted every two years to eliminate corrosion. The entire interior should also be painted. If the top is of stainless steel, any loose corners or cracks should be soldered.

Sectional Steamers.—The interior should be dried thoroughly after use in order to eliminate corrosion which is the worst enemy of this type of

equipment. The doors should be checked to see that no steam escapes; new gaskets may be needed. Aluminum paint mixed with a waterproofing compound will prolong the life of a sectional steamer by several years. It should be sprayed or brushed on the inside of each compartment, including the doors. It can also be put on the outside. Steamers should be repainted with this mixture every year. Valves should be checked and replaced if necessary.

Jacketed Steamers.—Jacketed steamers are usually aluminum. It was once thought that leaks in these kettles could not be repaired but it is now possible to do so by welding. If there is a local welder, he may be able to purchase aluminum strips for such repairs. The manufacturers do not repair leaks.

Sinks.—All galvanized iron sinks should be dried thoroughly after using. Exteriors should be painted. Faucets should be checked for leakage. The local plumber can do this if there is no maintenance man.

Steam Tables.—If gas burners are used for heating steam tables, it is especially important to de-lime the water pans as the lime will cause holes in the pans over the burners. The pans should be drained daily, washed and dried. Leaks should be soldered or otherwise patched. Loose corners should be soldered. A detergent that prevents the depositing of lime should be added to the water when the steam table is filled as it is easier to prevent the formation of the deposit than to remove it once it has formed.

Refrigerators.—The doors should be checked and new gaskets put in if needed. A local refrigeration man should check the compressor and coils every thirty days, for these items are not replaceable.

Coffee Urns.—This equipment should be de-limed every six months. The faucets should be checked for leakage. They can be reground if necessary. If gas is used, the flame should be controlled so that it does not burn the nickel plating. If steam is used it may be necessary to replace the coils inside the urn for quicker heating as they fill with lime in hard water regions.

Cooking Utensils.—Aluminum utensils, if burned through, can be rewelded and put into usable con-

dition. Handles can be replaced. Retinned stock pots can be tinned again if any tin is available.

Cutlery.—Knives can be repointed and resharpened. Knives with broken blades, unless very short, should not be discarded for they can be repointed and will still be useful for some purposes. New handles can be put on any blades that are still usable.

Silver.—Now is the time to get out old silver and refurbish it. Tines of forks can be straightened. All pieces that are not in too bad condition can be replated. Manufacturers are making no silver plate on the 18 per cent nickel base which was the best for these pieces. A plain steel base is being used now but this rusts badly so that the silver must not be allowed to stand in water or any other liquid and must be dried thoroughly as soon as possible after washing.

Glass.—A new so-called unbreakable glass may lower glass costs by reducing breakage.

China.—Some of the ingredients used in institutional china are becoming scarce. Decalcomania decorations may be eliminated, due to scarcity of some of the colors, so that we may be using undecorated china. The tan bodies may be discontinued, it is rumored. Replacements of the tan body or decorated china, therefore, should be made at once.

Besides the wearing out of equipment resulting from ordinary wear and tear and lack of proper maintenance, there are other possible causes of losses, such as theft, breakage and mixing in with garbage. Silver, cutlery and such small items as peppers and salts and ash trays are most likely to be stolen. In commercial situations, customers sometimes take these items; thus employees are not responsible for all of the losses. In college dormitories, students sometimes carry such items to their rooms and fail to return them. It is difficult to control customer thefts. It is not always easy to control employee thefts except in the case of food that can be locked up.

Equipment is not so easily kept under lock and key though it is definitely wise to lock the silver drawers and to let it be known that a silver inventory is taken at regular intervals. This has a good psycho-

logical effect. Silver can be weighed instead of counted in order to save time. Some kitchens provide no paring knives, employes being expected to furnish their own to guard against losses in garbage and by theft.

Checking garbage for silver, cutlery, butter chips and other small pieces can be done by spreading the garbage out and running a rake through it. Garbage haulers can be contacted and items recovered from them. Usually, they expect to be paid.

Similarly, breakage is not always easy to control. Breakage in the kitchen may be a question of too

little space on the soiled dish tables, too high stacking of trays or improper stacking of trays. A certain college dormitory reduced its breakage considerably by supplementing its clean dish space, which was inadequate, with some two deck carts wheeled into place at right angles to the table and moved away when full. Another accomplished the same purpose by placing rubber floor mats along the entire dishwashing layout. The floor was quarry tile and any dish dropped on it was almost inevitably broken.

Some institutions charge employes for breakage while others feel it is bad practice. It is frequently hard

to place the blame for any breakage and employes always resent such charges. A better scheme, perhaps, is to keep records of each person's breakage and then to say to those whose records are obviously bad, "You are costing us too much in breakage. Unless you can reduce this, we cannot afford to retain you in our employ."

It is most important to elicit the interest of the employes in prolonging the life of equipment. To that end, meetings for employes might be held to acquaint them with the impossibility of replacement and to show them how, by proper care of equipment, they aid the war effort.

Cold Plates for Sunday Suppers

DORIS PATTESON

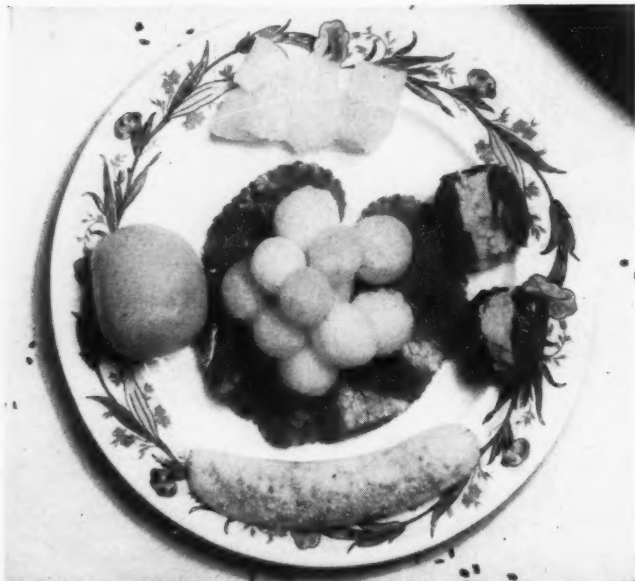
Dietitian, Spartanburg General Hospital, Spartanburg, S. C.

GENERALLY speaking, the Sunday evening meal has less variety than any throughout the week. There is a temptation to exhaust one's resources on an elaborate midday meal and let supper more or less take care of itself.

When selective menus are used, most Sunday suppers include hot combinations and cold plates as the main courses, one of which may be chosen by the patient. The hot dishes are more frequently chosen by the men while the women usually prefer the cold plates. Since there is nothing

distinctly "Sunday nightish" about these foods, we shall consider variety in cold plates.

The cold cut-potato salad and salmon salad-potato chip combinations appear too frequently. For variety one should serve light, dainty dishes that create a party spirit. It is surprising how much comment they evoke, particularly from women patients, if they are planned originally and carried out carefully. They are time-consuming, but the dietitian is repaid because of the satisfaction they give to all types of patients.



Fruit plate No. 3 with melon balls, dates stuffed with Cheddar cheese, banana soaked in orange juice and a pickled peach.

Fruit plates may be very attractive if they have variety in color, shape and flavor and if they are carefully prepared and served chilled. If they must be hurriedly thrown together, it is better not to serve them at all. One must beware also of serving those with eye appeal but with no taste distinctions. We must see that they contain a variety of flavors and textures. The following are examples of some we have used.

FRUIT PLATES

1. In the center a mound of cottage cheese on a lettuce leaf topped with a pimiento cross, flanked by prunes stuffed with walnuts, a pineapple spear garnished with green maraschino cherries, half of an inverted pear sprinkled with coconut and a mound of Royal Anne cherries.

2. A center pineapple star with a rosette of cream cheese on top surrounded by Mandarin orange slices. Around this, alternate slices of grapefruit and avocado pears with a cup of French dressing, dried figs stuffed with peanut butter, blue plums and a cluster of spiced grapes.

3. Cantaloupe and watermelon balls on a galax leaf in the middle, surrounded by dates stuffed with Cheddar cheese and nuts, whole spiced peaches, banana halves soaked in orange juice and dotted with chocolate shots and diced minted pineapple.

4. A honeydew melon ring with toasted coconut on the edge, sur-



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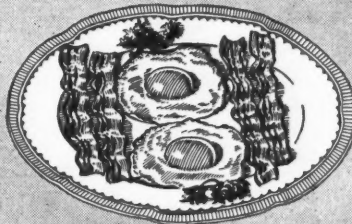
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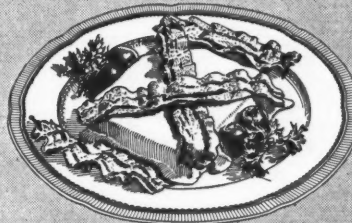


*Here's a Handful of Hot Weather
Bacon Dishes That Are Welcome
on the Hospital Trays!*

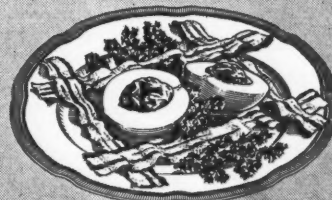
STAR BACON BREAKFAST



STAR BACON AND MELTED CHEESE SANDWICH WITH RELISH



STAR BACON AND BROILED PEACHES



Supper Menus Built Around Cold Plate

I

Cream of green pea soup popcorn
Fruit plate Assorted sandwiches
Macaroon floating island
Coffee Tea Cocoa Milk

II

Cream of chicken soup
Souffléed crackers*
Vegetable plate
Hot rolls Guava jelly
Coffee ice cream, hot fudge sauce
Coffee Tea Cocoa Milk

III

Consommé Croutons
Sandwich loaf*
Potato chips Jelried orange and
honeydew melon salad
Peppermint blancmange, chocolate
sauce
Coffee Tea Cocoa Milk

IV

Fresh fruit cup with orange ice
Hot club sandwiches Potato sticks
Black olives
Pineapple, date and celery salad
Lime gelatin, whipped cream
Coffee Tea Cocoa Milk

V

Hot spiced punch
Cold sliced Maryland turkey,
Western roast beef
Tomatoes stuffed with potato salad
Celery curls Cranberry relish*
Mince meat upside-down cake
Coffee Tea Cocoa Milk

VI

Black bean soup, lemon slices
Open salad sandwich*
Head lettuce, Roquefort dressing
Red raspberries, whipped cream
Gingersnaps
Coffee Tea Cocoa Milk

Recipes are given for the items
marked with an asterisk (*).

rounded by watercress and filled with Bing cherries, white grapes, honeydew balls and a pineapple spear. This is very light and unless more nourishing foods accompany it, it might better be used as an appetizer.

5. A mound of strawberries on watercress encircled by banana balls dipped in lemon juice and coconut, a slice of canned pineapple topped with pimiento cheese decorated by a date, spiced apricots, and grapefruit and orange sections alternating.

6. A lettuce cup filled with cottage cheese on top of which is a walnut half. Around it are arranged prunes stuffed with figs, orange slices, avocado balls (mashed, seasoned and shaped) and an inverted half pear decorated by strips of green pepper inserted parallel into the soft meat.

To any of these may be added cups of mayonnaise or one of the fruit dressings, depending upon the fruits served. The number of combinations that might be used is endless.

The vegetable plate does not have the popular appeal of the fruit plate; however, it lends variety and may be used occasionally. It is important to see that all the vegetables are properly seasoned before they are assembled, for cold, unseasoned vegetables are tasteless indeed. A few combinations are given below.

VEGETABLE PLATES

1. A pimiento cup filled with coleslaw in the center; around it hard cooked eggs, spinach mousse, carrot straws and diced potato salad on curly endive.

2. Stuffed eggs garnished with a ring of stuffed olives, sliced tomatoes, potato sticks, pepper rings and head lettuce with Roquefort cheese dressing.

3. Cucumber boats filled with a mixture of cabbage, diced cucumbers and celery cubes marinated with French dressing, in the center; a wedge of Cheddar cheese, lattice potato chips

and green pea and egg salad, all on a bed of one's favorite salad green.

4. Celery stuffed with nuts and cream cheese, molded macaroni salad, radish roses, asparagus tips and romaine with anchovy dressing.

Now we shall consider menus in which a fruit plate, a vegetable plate and other cold dishes are used. With these cold plates it is necessary to serve a hot soup, beverage or dessert to give the differences in temperature necessary to any menu.

OTHER COLD PLATES

Other cold plates might be (1) assorted sandwiches, such as rolled watercress, cream cheese and guava jelly, peanut butter and minced ham, and egg salad. The three latter should be on different breads cut in various shapes. (2) Jelried meat, fish or chicken loaves and salads. (3) Tomatoes stuffed with crab, tunafish, chicken, salmon or shrimp. (4) All-in-one salad—diced potatoes, celery, cabbage, cubed cold meats and mayonnaise, garnished with ripe olives and served on lettuce. (5) Salad plates, having assorted salads on them, such as fruit salad, a vegetable salad, a potato salad, and a meat, fish, egg or cheese salad.

These plates should be as pleasing to look at as good pictures, and if the flavor is equal, the gourmet will enjoy them much more.

Recipes for Supper Dishes

Souffléed Crackers

Cover round soda crackers with cold water and allow them to soak until they are doubled in size; then lift each with a pancake turner or spatula onto a thoroughly greased baking sheet; dot each cracker with small bits of butter. Put the sheet into an oven preheated to 400° F. and allow to brown quickly. —*American Cookery Magazine.*

Sandwich Loaf

A loaf of white sandwich bread is sliced lengthwise into four long slices and is put together again with a stuffed olive and cream cheese mixture between the first two layers, chicken salad between the next two and tomatoes and mayonnaise between the last two. The loaf is iced with cream cheese, which may be tinted if desired. (This recipe is probably familiar to all dietitians.)

Cranberry Relish (Raw)

(50 Portions)		
Amount	Ingredients	Method
4 (size 150)	Oranges	
4 pounds	Cranberries, raw	Grind
6 pounds	Apples (remove cores)	
3 pounds	Add sugar	

Chill for twenty-four hours before using. Serving: approximately three ounces. Note: May be used as salad if drained before using.—*"Food for Fifty," Fowler and West.*

Open Salad Sandwich

The edges are trimmed from two slices of toasted and buttered raisin bread. A thick layer of mayonnaise is then spread over both slices. On one is placed baked ham with four slices of hard cooked egg on top; on the other, a slice of tomato with asparagus tips arranged around it. It is garnished with stuffed olives and celery curls.

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SPITAL



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CHICKEN SOUP

Vol. 59, No. 2, August 1942

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September Menus for the Small Hospital

Margaret Mines

Dietitian, Pocatello General Hospital, Pocatello, Idaho

BREAKFAST

LUNCHEON OR SUPPER

Day	Fruit	Main Dish	Soup	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Pineapple Juice	Soft Boiled Eggs, Toast	Cream of Mushroom	Spaghetti With Tomatoes, Cheese and Bacon		Lettuce Salad, Ripe Olives	Apricots, Cookies
2.	Sliced Oranges	Poached Eggs, Toast	Cream of Carrot	Cold Meat	Sliced Tomatoes	Potato Salad	Peaches, Cookies
3.	Dried Apricots	Soft Boiled Eggs, Whole Wheat Muffins, Jam	Cream of Pea	Escalloped Asparagus	Sliced Tomatoes	Egg Salad	Plums, Brownies
4.	Sliced Oranges	Scrambled Eggs, Toast	Cream of Celery	Cottage Cheese, Sliced Tomatoes	Cornbread With Jam	Combination Fruit Salad	Raspberries
5.	Applesauce	Poached Eggs, Toast	Cream of Spinach	Creamed Dried Beef on Toast	Sliced Tomatoes, Beet Pickles	Lettuce Salad	Peaches, Cookies
6.	Cantaloupe	Bacon, Toast or Pancakes	Cream of Pea	Sandwiches	Potato Chips, Olives, Pickles	Perfection Salad	Plums, Cake
7.	Orange Juice	Scrambled Eggs, Toast	Cream of Celery	Escalloped Asparagus	Sliced Tomatoes	Combination Fruit Salad	Caramel Cake
8.	Grapefruit	Soft Boiled Eggs, Toast	Cream of Mushroom	Escalloped Tuna and Noodles	Sliced Tomatoes	Carrot and Raisin Salad	Peaches, Cookies
9.	Bananas	Bacon, Toast	Cream of Potato	Cold Meat	Lima or Baked Beans	Tomato Salad	Raspberries, Oatmeal Cookies
10.	Sliced Oranges	Soft Boiled Eggs, Muffins, Jam	Cream of Carrot	Cottage Cheese, Raisin Bread	Wilted Lettuce	Macaroni Salad	Watermelon
11.	Grapefruit	Poached Eggs, Toast	Cream of Pea	Potato Salad	Ripe Olives, Beet Pickles	Tomato Stuffed With Cottage Cheese	Peaches, Cookies
12.	Figs	Soft Boiled Eggs, Toast	Cream of Asparagus	Spanish Rice	Celery	Peas-Egg-Cheese Salad	Pineapple, Cookies
13.	Cantaloupe	Bacon, Sweet Rolls or Pancakes	Cream of Celery	Sandwiches	Potato Chips, Ripe Olives	Combination Vegetable Salad	Grapes
14.	Orange Juice	Soft Boiled Eggs, Toast	Cream of Spinach	Stew	Sliced Tomatoes	Banana Salad	Raspberries, Cookies
15.	Cantaloupe	Poached Eggs, Toast	Cream of Potato	Creamed Dried Beef on Toast	Celery	Asparagus Salad	Fruit Gelatin
16.	Grapefruit	Scrambled Eggs, Toast	Cream of Mushroom	Toasted Cheese Sandwich	Ripe Olives	Carrot and Pine-apple Salad	Watermelon
17.	Sliced Oranges	Bacon, Toast	Cream of Pea	Cold Meat	Sliced Tomatoes	Combination Fruit Salad	Chocolate Cake
18.	Pineapple Juice	Poached Eggs, Toast	Cream of Spinach	Stuffed Eggs	Potato Salad	Sliced Tomatoes	Peaches, Cookies
19.	Bananas	Coddled Eggs, Toast	Cream of Carrot	Creamed Chicken	Sliced Tomatoes	Lettuce Salad	Raspberries, Cookies
20.	Cantaloupe	Scrambled Eggs, Toast or Pancakes	Cream of Mushroom	Sandwiches	Potato Chips, Ripe Olives	Salmon Salad	Watermelon
21.	Applesauce	Soft Boiled Eggs, Coffee Cake With Jam	Cream of Celery	Spaghetti With Tomatoes and Bacon	Raisin Bread, Beet Pickles	Pear and Grated Cheese Salad	Apricots, Cookies
22.	Pineapple Juice	Scrambled Eggs, Toast	Cream of Asparagus	Stew	Cornbread, Beet Pickles	Combination Vegetable Salad	Grapes
23.	Grapefruit	Soft Boiled Eggs, Toast	Cream of Spinach	Cottage Cheese	Sliced Tomatoes	Green Bean Salad	Apricots, Cookies
24.	Bananas	Bacon, Toast	Cream of Pea	Cold Meat, Sliced Tomatoes	Dutch Bread	Macaroni Salad	Cantaloupe or Watermelon
25.	Prunes	Soft Boiled Eggs, Muffins, Jam	Cream of Celery	Toasted Cheese Sandwich	Ripe Olives	Asparagus Salad	Peaches, Cookies
26.	Sliced Oranges	Poached Eggs, Toast	Cream of Mushroom	Creamed Rice	Sliced Tomatoes	Egg Salad	Pineapple
27.	Cantaloupe	Bacon, Toast or Pancakes	Cream of Asparagus	Sandwiches	Potato Chips, Ripe Olives	Combination Vegetable Salad	Watermelon
28.	Figs	Scrambled Eggs, Toast	Cream of Tomato	Stew	Honey, Baking Powder Biscuits	Celery-Orange-Coconut Salad	Grapes
29.	Grapefruit	Soft Boiled Eggs, Sweet Rolls	Cream of Spinach	Cream Dried Beef on Toast	Sliced Tomatoes	Carrot and Raisin Salad	Peaches, Cookies
30.	Bananas	Bacon, Toast	Cream of Celery	Omelet	Sliced Tomatoes	Perfection Salad	Pears, Caramel Cake

If you find the repetition of some foods often it is because there have been calls for them in our hospital. You will note we have cream soups every evening. This makes it possible for us to have plain vegetables oftener as so many do not like creamed vegetables. Our cream soups are not thickened. One thing we have found to be convenient and well liked by the nurses is a buffet supper on Sunday. We furnish the materials for salads and sandwiches and they make their own.

Recipes will be supplied on request by The MODERN HOSPITAL, Chicago.

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Hospital Care for the Diabetic

ELLIOTT P. JOSLIN, M.D.

Medical Director, George F. Baker Clinic, New England Deaconess Hospital, Boston

INCREASINGLY, diabetics are entering hospitals. The admissions will continue to rise because the number of diabetics is growing and because diabetics are living so long that they not only are developing the complications of their disease but are acquiring other diseases the treatment of which, in the presence of diabetes, becomes intricate, requiring special care.

All too slowly are hospitals adjusting their methods to this influx of a new class of patients. A considerable portion is not bedridden, yet in most hospitals these patients are grouped in wards with the sickest of the sick and, perforce, are treated as invalids. At home diabetics work but in the hospital they are kept in bed until the doctor makes his visit. As for exercise, that important component of the trilogy of diabetic treatment, they get none and, consequently, are discharged unadjusted to their customary daily life of activity.

More or Cheaper Hospitalization

Of course, many diabetics are treated in out-patient departments but many others need hospitalization until control and regulation of the disease are established and understood by the patient. This custodial and educational type of hospitalization should become commoner and far less expensive. This problem is solved for children by sending them to diabetic camps in the summertime where treatment can be carried out for half that of the hospital cost.

Custodial and educational provision should be made for their diabetic clientèle by all hospitals of con-

siderable size. A diabetic in a ward can wash his feet as well as his face and should be allowed to do so. Hygiene of the body and a hygienic diet adapted to their condition should be taught to diabetic patients morning, noon and night. They do not need to have a tray carried to their beds. They can go to a dining room or cafeteria. The expense should not be great because an attendant can oversee the bedmaking and the washings under a nurse's supervision. A waitress can serve the food.

As for the education of the diabetic, hospital administrators need not worry, but rather should lay that responsibility upon the doctors. Will the doctors assume it? They certainly will if they want to treat diabetics because these patients like to be taught and they tell one another from which doctors they learn the most.

Most hospitalized diabetics have diseases complicating their diabetes. If the diabetic service is a large one, practically all the specialties in the hospital are involved in their care. Surgeons for the extremities and the abdomen, gynecologists and obstetricians, otologists, laryngologists and ophthalmologists, orthopedists, neurologists, chest surgeons, dental surgeons and roentgenologists are always in demand.

The contacts among the different services are so many and so stimulating that breadth of view is fostered in the medical men who shepherd the group. In general, it is easier for the specialists to have their diabetic patients treated in the medical ward because while under observation they require detailed diabetic care.

The laboratory in a hospital is a lifesaving station for diabetics; around it all diabetic care revolves.

Diabetics should be taught its value and their dependence upon it. To do its part the hospital should recognize this fact and endeavor to make the laboratory available to the greatest number of diabetics, both in and outside the hospital walls. The usefulness of the laboratory should be exploited. Far more blood sugar tests should be performed; they would be, if the costs were lower.

Coupon Books, Bargain Days

To offset the cost of such tests to the hospital, arrangements should be made so that various unnecessary elements in the expense are eliminated. This can be done by grouping the tests on one or more days of the week and at special hours of each day. To encourage more tests by the patient and his doctors after he is discharged, the hospital laboratory might sell coupon blood sugar books good for a year from date at reduced rates. Bargain blood sugar days and blood sugar coupon books certainly would minimize expense.

Even for in-patients, expense could be reduced by having ambulatory patients report to the laboratory for their tests instead of wasting the time of a technician hunting for them. The time spent in collecting the blood and in charting the results at the bedside amounts to about as much in dollars and cents as the performance of the test. The cost of a single blood sugar test, if done in multiples, is about 50 cents and not the \$5 that some laboratories still charge when tests are done singly.

Instruction to patients should be both individual and in classes. It should not be limited to in-patients or out-patients alone but should be designed also for their families and friends.

Accommodations for transient guests should be provided. Ordinarily, in a hospital an accident room

Doctor Joslin requests that Howard F. Root, M.D., Priscilla White, M.D., Alexander Marble, M.D., and Allen P. Joslin, M.D., be considered co-authors of this article.



"But, Bertha, maybe they can't help the smell"

THOSE employed in hospitals get so used to "hospital odor" that they don't notice it. But patients sense it quickly and it often contributes to their natural nervousness and apprehension. Visitors don't like it too well, either.

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serves the purpose and it is true that for incipient cases of insulin shock the accident room might suffice. For severe types of hypoglycemia or for any type of diabetic coma this would not do because of the length of time required for recovery. Furthermore, along with the strictly medical treatment of these conditions, psychological as well as medical instruction is demanded to prevent a recurrence. Hospitals should welcome such temporary emergency admissions and make the 700,000 or more diabetics in the country feel free to return for temporary service and encourage readmissions for periodical checkups.

Diabetic deaths occasionally occur because the difference between diabetic coma and an insulin shock is not recognized. Examples of this are more frequent than I would care to mention. The differential diagnosis is by no means always clear. The laboratory must be available to help out in such emergencies night and day, holidays and Sundays.

From the Precedent Book

Although the variation in the severity of diabetes, the age of the patient and the type of complication make it impossible to reduce diabetic treatment to any routine, certain methods have precedence at the New England Deaconess Hospital. These methods change from time to time but at present may be summarized as follows:

Admission of Patient. An immediate physical examination of the patient is made and a history taken and recorded on the diabetic history sheet with special attention to the previous treatment, including the preceding diet and the qualitative and quantitative insulin dosage. It is often desirable to record in pencil the date of onset and occasionally other answers for subsequent cross examination. The nurse obtains the admission urine specimen, which she tests immediately for sugar and diacetic acid, and then forwards it and a blood sugar specimen to the laboratory.

Laboratory. The urine is collected in twenty-four hour specimens daily and the percentage and total excretion of sugar in grams for the twenty-four hours are charted on a single diabetic chart that provides space on one line for each day for all analyses of the urine and blood. This chart

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DIABETIC DIETS

DIETS	TOTAL DIET				CARBOHYDRATE (C)						PROTEIN and FAT (PF)				
	CARBOHYDRATE	PROTEIN	FAT	CALORIES	5% Vegetables	ORANGE	OAT-MEAL	POTATO	BREAD	MILK	EGG	MEAT	BACON	20% CREAM	BUTTER
C1 PF1	121	53	64	1272	300	400	15	90	45	240	1	75		120	15
C2 PF2	136	60	71	1423	300	400	15	120	60	240	1	90		120	20
C3 PF3	151	70	80	1604	300	400	15	150	75	240	1	120		120	25
C4 PF4	165	82	97	1861	300	450	15	150	90	240	1	150	15	120	30
C5 PF5	180	89	103	2003	300	450	15	180	105	240	1	165	15	120	35
C6 PF6	199	99	123	2299	300	450	30	180	120	240	1	180	30	120	45
ACUTE ILLNESS	152	50	52	1276		400	15		90	960	1				15

Approximate equivalents. 1 small orange (100 gms)= ½ banana (50 gms)= ½ saucer oatmeal (15 gms dry or 120 gms cooked)=2 large saucers (300 gms) 5% vegetables= 1 large saucer (150 gms) 10% vegetables= potato size of egg= ½ slice (15 gms) bread.

On the reverse side of this card given to patients is printed an extensive list of vegetables and fruits arranged as to their carbohydrate content.

also shows on the same line the grams of carbohydrate, protein, fat and the calories in the diet as actually eaten, the weight of patient and the insulin given. A space is reserved for remarks. It is possible, therefore, to see at a glance on one sheet what the changes in urine and blood have been during the preceding day or even ten days.

In addition to the twenty-four hour urinalysis, frequently single specimens of urine are tested by the floor nurse at regular intervals daily, especially when a patient is undergoing rapid adjustment to diet and insulin. If such specimens show considerable quantities of sugar or no sugar at all, the insulin order is planned accordingly, providing for an increase, decrease or no insulin as the tests warrant. To avoid a false inference from the test of the specimen accumulated during the night but voided on rising, another specimen should be obtained for analysis one half hour later if the first was positive for sugar.

Blood sugar determinations are made regularly two or three times a week but they are made more often for patients whose hospital stay is brief, usually on the day before discharge. Emergency blood sugar analyses are carried out and reported within thirty minutes to an hour in patients in severe acidosis or coma and when symptoms suggesting the possibility of a hypoglycemic insulin reaction are present. For the latter cases, 5 or 10 grams of carbohydrate may be given if the nurse is in doubt, but only on the rarest occasion is this done until the sample of blood has been drawn, although the

report of the blood analysis may be deferred for some hours.

Diet. All diabetic diets are prescribed as weighed diets and food not eaten is subtracted so that the actual food consumed can be expressed in grams of carbohydrate, protein and fat and calories per twenty-four hours. In general, adult patients, upon admission, receive a diet providing daily for 20 to 25 calories per kilogram body weight furnished in part by carbohydrate 120 to 150 grams. After a preliminary period, the diet is gradually altered so that by the end of a week or ten days most patients will be receiving approximately 30 to 35 calories per kilogram body weight, according to age and activity (much more for growing children) and about 150 to 180 grams of carbohydrate.

No Special Foods Prescribed

The accompanying table of diets has been employed at the New England Deaconess Hospital for a number of years because of simplicity and ease of instruction both for patients and nurses. No special diabetic foods are prescribed.

A bedtime lunch of 10 grams of carbohydrate and often protein-containing foods, such as cheese, milk or nuts, is given to patients taking protamine zinc insulin. Most children and patients during their adjustment to insulin receive also a lunch at 10:30 a.m. and 3:30 p.m. During acute illnesses, any food suitable to the complication is allowed in weighed amounts and the glycosuria is controlled with supplementary small doses of crystalline insulin

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according to the urine test results.

Exercise. Patients are allowed out of bed as soon as possible and daily walks out of doors are recommended whenever conditions permit. Confinement to bed is avoided because it deprives the patient of the muscular exercise that adds to the efficiency of insulin and dietary treatment.

Insulin. Protamine zinc insulin, given daily before breakfast, is used with almost all patients. It is used alone in about one third of the cases. In about one half of the cases it is supplemented with crystalline insulin, by separate injection, before breakfast. The latter plan is adopted particularly with children and young

adults. Only occasionally before the other meals or at bedtime, according to single specimens of urine obtained, is crystalline insulin employed. Orders for such single specimen tests are usually written so that a single specimen is tested before each meal and insulin injected in accordance with the color of the Benedict test. Thus, such an order might be 12 units if red, 8 if orange, 4 if yellow and none if green or blue.

$$\left[\frac{R}{12} = \frac{\text{Or}}{8} = \frac{Y}{4} \right]$$

By the time the patient is ready for discharge, the aim is to have all of the insulin injected before break-

fast. A common prescription would be 12 units of crystalline insulin and 32 units of protamine zinc insulin. In cases of unusual severity or cases of insulin resistance, much larger doses of insulin will be required. An endeavor is made to prescribe insulin in numbers of units divisible by four, because U-40 strength insulin is most often dispensed and our one cubic centimeter syringes are graduated in tenths.

Protamine zinc insulin is given in quantities sufficient to maintain the blood sugar between 100 and 150 mg. per hundred cubic centimeters before breakfast and when needed crystalline insulin is added to maintain this same level before the noon and night meals. There is no rule for the first dose, but consideration of previous dosage, quantity and quality, the need for haste in controlling the glycosuria, allowance for gradual development of treatment in the old and the possibility for rapid treatment in the young must be considered.

Education of Patients. Class instruction consists of a lecture at 10:30 each morning by physicians in charge of diabetic treatment and a recitation at 1:15 p.m. conducted by a nurse, dietitian or dental hygienist. In these classes, which last from thirty to forty-five minutes, questions are encouraged. The aim of instruction is to explain the nature of diabetes and its symptoms, the use of insulin and the calculation of the diet, the demonstration of the Benedict test and a discussion of the prevention of complications, such as insulin reactions and acidosis, as well as infections of the feet and skin. The visiting chiropodist sees patients at the hospital each week.

An examination of the teeth by the dental hygienist is provided for every diabetic patient. A prophylactic foot treatment is given by the special surgical foot nurse who emphasizes cleanliness, care of corns and calluses, trimming of the nails and who demonstrates the use of lanolin for softening the skin and preventing fissures. The discharge diet list given to the patient includes a summary of the important points dealing with the care of both the teeth and the feet.

The concluding section of Doctor Joslin's article will appear in the September issue.

Novak Method of Plasma Storage Is Disputed

"A Safe Way to Store Plasma" (Mod. Hosp. 59:94 [July] 1942) is not safe, according to Dr. M. V. Veldee, chief of the division of biologics control, U. S. Public Health Service.

Dr. Milan Novak's laboratory studies on the use of the sulfonamides for controlling the problem of bacterial contamination are not borne out by the experiments of other investigators, Doctor Veldee points out in a letter to the *Journal of the American Medical Association*, which also printed an account of Doctor Novak's studies.

"In view of the present interest in human plasma for use in both military and civilian medicine, Doctor Novak's report will attract widespread attention," Doctor Veldee writes.

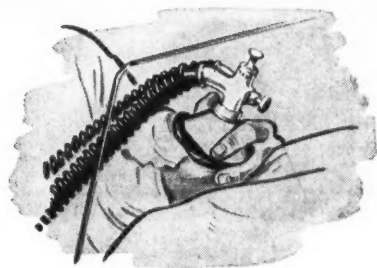
"My attention has been called to this report by the author's results being at wide variance with other available data. Because of the urgency of the problem, Dr. Margaret Pittman was assigned the task of checking Doctor Novak's work as nearly as could be done from reading this report.

"Using five different species of bacteria and one lot of pooled plasma and one of serum, and after exposing the bacteria to the drug-treated plasma or serum at three different

temperature levels and culturing three times during a period of approximately thirty days, she was unable to find any evidence that 0.2 per cent sodium sulfathiazole had an inhibiting effect to a degree to be of significance when used in processing plasma or serum. Since this study was undertaken, Heath and Province have reported their observations, which confirm Pittman's results.

"This study was repeated with whole blood in order to ascertain whether the action of sodium sulfathiazole would be different in the presence of the cellular elements of the blood. Here, again, the blood failed to exert any retarding action on the bacteria used and under the conditions of the test as described by Doctor Pittman.

"It is regrettable that Doctor Novak should hold that the addition of 0.2 per cent sodium sulfathiazole to the bleeding bottle is justification for indifferent technic in drawing blood or in recovering the plasma. Up until now there is no known acceptable bactericidal agent that will accomplish this. On the other hand, qualified technicians using the aseptic bleeding technic, followed by a closed system of processing the plasma, can produce a sterile product even on large scale production."



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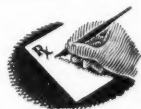
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NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D.
Arnold J. Lehman, M.D., and Harold Chase, M.D.

Some Pharmacologic Problems of High Altitude Flying

The behavior of the human organism resulting from changes in altitude has been studied probably as long as any subject related to medicine. The symptoms that develop in individuals who ascend high mountains are mentioned in medical writings centuries old. Much of the earlier knowledge was obtained by observing the responses that occurred during mountain climbing or while residing at high elevations; such information may not necessarily be adaptable to the new conditions governing travel on the air routes.

Mountaineering is a slow process carried out at the expense of considerable muscular activity and residence at high altitudes presents an opportunity for adaptation. In high flying or even present day cross-country automobile trips over high mountains the traveler passively ascends and descends rapidly, remaining at high elevations for a relatively short period of time and adaptative mechanisms have little opportunity to function.

Attempts have been made to develop and extend the original concepts concerning disturbances in bodily functions at reduced barometric and oxygen pressures by direct experimentation on man, employing the decompression chamber. While such observations furnish much valuable information regarding the effects of high altitude, the results can be only partially applied to air travel. The environmental situations during flight are not dependent entirely on atmospheric pressure and oxygen tension but are contingent also upon accelerational and centrifugal forces which come into play whenever the course of the aircraft is altered. These forces have the additional factors of magnitude, whether imposed on the long or short axis of the body, as well as of duration of their action.

Of the many problems concerned with human performance at high altitude the effect of low oxygen tension has probably received more than its share of attention.

Various decompression experiments have fairly well established the influence of anoxia. On first thought the correction of the difficulties encountered by the lack of oxygen appears simple enough. The administration of the gas in sufficient concentration to maintain hemoglobin saturation should be the solution

but certain difficulties enter the picture and all of them are not purely mechanical.

Oxygen Toxicity

- Prolonged exposure to pure oxygen is not without its hazards. Heim has investigated the effects of continuous exposure to 100 per cent oxygen on rabbits. Animals that were allowed to breathe the pure gas in a decompression chamber at a reduced pressure, simulating 5000 feet altitude, died within seven days. At 10,000 feet symptoms of oxygen poisoning developed within ten days and only an occasional animal died, whereas at 20,000 feet no untoward symptoms were noted during the observation period of about eight days. He concluded from this that in normal individuals the duration of exposure to pure oxygen during a flight would in all probability never be long enough for oxygen poisoning to become evident.

However, general experience indicates that oxygen poisoning is not rare. Behnke and Wellmon list the symptoms as generalized weakness and nausea, appearance of wheals, flushing of the face and dermatitis. These disturbances apparently are caused by some noteworthy changes in the blood and circulation. The red cells decrease in number by from 7 to 8 per cent, hemoglobin is reduced 3 to 5 per cent and oxygen content of the blood is increased by 10 to 15 per cent. The changes occur within minutes and no doubt the sequence of events as given above may be a reaction of the tissues to this change in environment.

Barometric Pressure

- Scant attention has been paid to the influence of the decrease of barometric pressure per se. Rapid reduction in atmospheric pressure produces the well-known phenomenon of aero-embolism, or "bends." This painful syndrome is the result of the formation of nitrogen bubbles in the tissues and blood stream. As yet no drugs have been developed to diminish the susceptibility to this condition but some progress has been made to aid denitrogenation. One method is to permit the susceptible individual to breathe pure oxygen for about five hours before ascent. By this means most of the dissolved tissue nitrogen is replaced.

Obviously, preoxygenation is not very practical and other procedures have been tried. Mixtures of helium and oxygen have been employed. Since helium is less soluble in body constituents than nitrogen, less of the gas is available for bubble formation and also less oxygen is necessary for replacement. An individual saturated with helium requires only ninety minutes' exposure to pure oxygen for the elimination of the dissolved gas.

Allergic Sensitivity

- One of the symptoms associated with low barometric pressure is a tingling and itching of the skin; occasionally, a red rash appears. The similarity of this rash to certain allergy responses has indicated that some relationship may exist between allergic manifestations and the effects of decreased atmospheric tension. Becker tested the neurogenic responses of the skin using epinephrine and morphine as the chemical irritants. He found that wheal formations resulting from morphine were small in size and of short duration at elevated heights as compared with the responses at lower altitudes. Epinephrine produced no significant changes. He concluded that the adaptability of the skin to cholinergic stimulation decreases with increases in altitude and that adaptability to sympathetic stimulation does not typically increase.

Kopaczewski in a similar vein determined the effects of altitude on guinea pigs sensitized to beef serum. His experiments carried out in the decompression chamber revealed that at a pressure corresponding to an altitude of 30,000 feet all of the sensitized pigs convulsed without injection of the antigen. Controls under similar conditions showed no symptoms. On slow descent all convulsing animals gradually recovered. He felt that these observations may have some bearing on air travelers who are asthmatic or susceptible to urticaria and eczema.

Centrifugal acceleration is the main cause of functional disturbances during flight. The effect of this force is measured in g, 1 g being the normal attraction of gravity. Man can withstand 5 or 6 g for a few seconds which means that during the acceleration the body has increased its weight five or six times. The weight of the blood becomes so great that the heart is unable to maintain circulation and either cerebral anemia and unconsciousness or cerebral congestion results depending on whether the acceleration is acting from head to feet or the reverse. Certain of the vasoconstrictor drugs have been suggested as possible aids for increasing the tolerance to g, among them a pancreatic hormone (vagotonin), epinephrine and

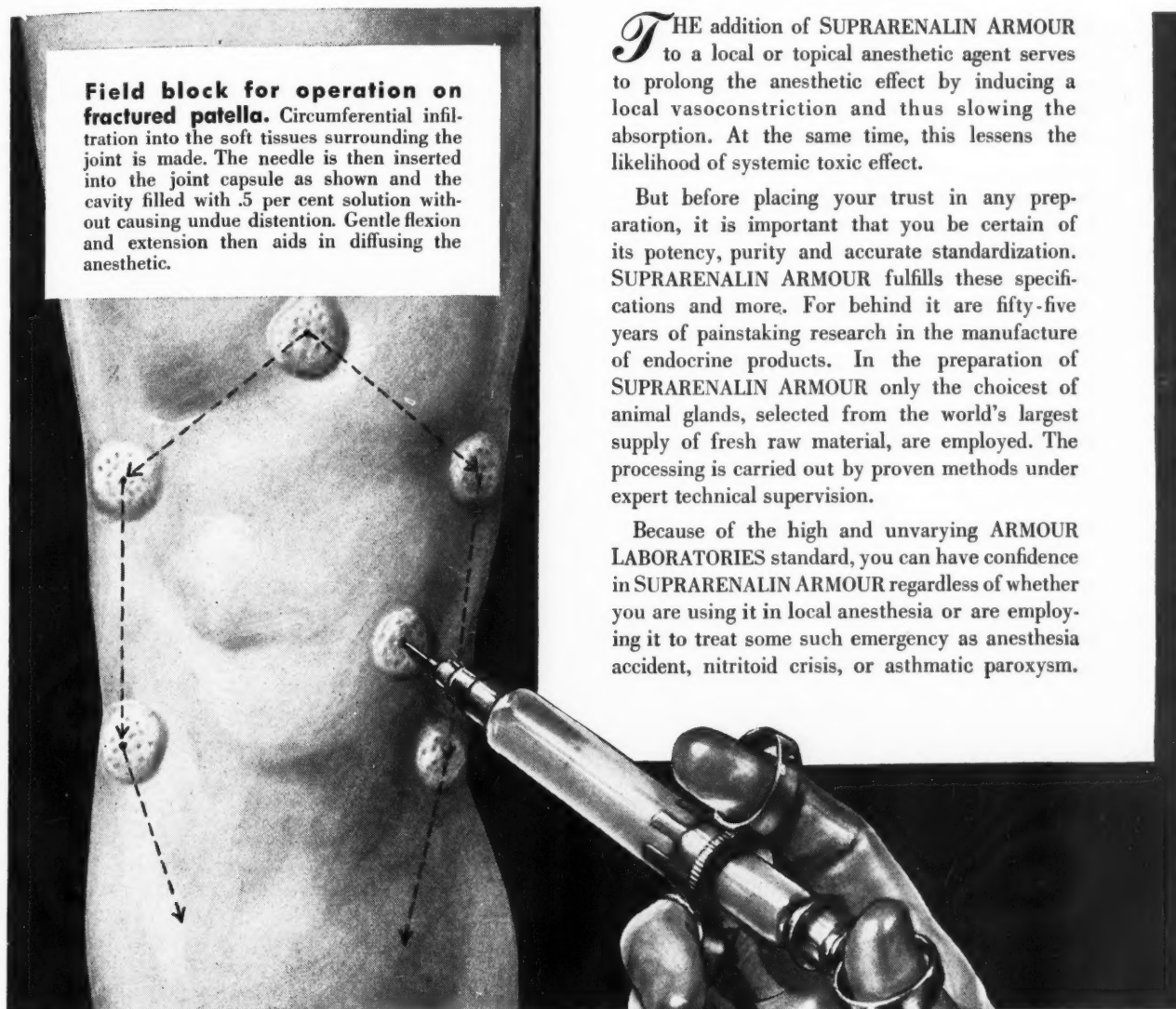
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pressor fractions from the pituitary, but evidence of any beneficial action is vague.

Drug Potentiation

• Since body functions are disturbed by reduced oxygen and atmospheric pressures, it would seem quite probable that the actions of drugs might be influenced also. Indeed, the general tendency appears to be that drug effects are intensified at high altitudes. The actions of hypnotics is notably reenforced. For instance, chloral hydrate administered to rabbits in doses that produced little or no effect at sea level demonstrated a strong hypnotic action at 10,000 feet. Similarly, alcohol gives a quicker rise to a higher maximum concentration in the

blood stream when comparable doses are administered at 12,000 feet than at sea level. Digitalis has about a 20 per cent increase in potency at 10,000 feet when tested in cats and pigeons. The action of strychnine is also intensified.

One of the most recent contributions along this line concerns the sulfone drugs. Altitude tolerance seems to be materially reduced following the administration of sulfanilamide. The exact mechanism is not clear. Methemoglobin formation may be partially responsible, but some recent observations on this phenomenon seem to indicate that it is a combination of circumstances which includes the drug and the individual as well as the possible presence of methemoglobin.—ARNOLD J. LEHMAN, M.D.

mittee and it is of the opinion that this cooperation, if not on a voluntary basis, should be effected by compulsion.

The committee also favors a state medical service and advises pharmacists to support the principle that the prevention and treatment of disease should be organized as a public service and that as a profession they should join with other interested bodies and individuals in devising the best form of organization that would embody this principle. Control of both the opening of new pharmacies and the channels of distribution as well as prices of medical products is advocated.

Control of advertising of proprietary drugs is also recommended, as is the avoidance of the use of different trade names, by manufacturing pharmacists, for the same medication. The pooling of research in pharmacology by the establishment of a central research institute is also recommended.

These proposals are revolutionary and their fulfillment would imply a fundamental change in the present attitude toward private enterprise.—NEWMAN M. BILLER.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Urogenital War Wounds

In "Wounds of Urogenital Tract in Modern Warfare," by Dr. Hugh H. Young in the *Journal of Urology* for February, the author presents an exhaustive study of wounds incurred during the first World War. He has divided his study into two parts. The first section, entitled "Collective Statistics and Case Reports From A.E.F. and Our Allies," is based on official reports, papers in the medical journals and personal communications made to Doctor Young. The second section, a "Discussion of Urogenital Wounds in Modern Warfare," is an analysis of the material presented in the first portion. It treats under separate headings the incidence, etiology, pathology, clinical picture, symptoms, signs and diagnosis of wounds of the kidney, ureter, bladder, genitalia and urethra.

During the last 25 years human ingenuity has unfortunately made such progress in the manufacture of high explosives that much of this experience is not directly applicable to the present conflict. However, a valuable residue remains and the hospital administrator would do well to read such review articles as these from time to time.—S. F. WILHELM, M.D.

When the Doctor is Sick

"It isn't the prescription that I give," said a great physician, "but the pat on the shoulder with which I give it."

The little mannerisms, the studied intonation and gesture are all used to good effect when treating the sick and they help to get the advice across with the ordinary patient. But how is it when the doctor, himself, is a patient?

The successful doctor's doctor must use another more tedious technic requiring great expenditure of time, repeated examination and a lengthy critical discussion without any of the trivialities.

"When Doc Meets Doc," according to the article, in the *Lancet* for Dec. 27, 1941, the relationship of doctor to doctor may be fraught with risk. There are too many tragic cases in which a doctor's life has been cut short because he had no real medical attention at all. The moral is clear. Refuse to discuss a doctor's ailment unless you are being asked to treat him. But if you are, treat him as you would any other patient and don't let him share the responsibility. When you yourself are ailing, choose your doctor as carefully as your lawyer, and put yourself unreservedly in his hands.—L. TARR, M.D.

The Future of Pharmacy

Pharmacy, as practiced in Great Britain, falls into an intermediate position between the professions and commerce, the *Lancet* for Jan. 24, 1942, reports. Pharmacists receive a purely scientific education of university standard and, when this is over, the majority spend the remainder of their lives as retail salesmen with little opportunity of utilizing their scientific knowledge. This anomalous position caused considerable dissatisfaction and, as a consequence, a committee of inquiry was set up by the British Pharmaceutical Society in 1937. Its final report, published Dec. 13, 1941, contains interesting recommendations.

The advantages inherent in multiple trading by cooperative groups (the approximate equivalent of the chain store in America) are recognized by the com-

Diagnosing Gastric Cancer

"The Diagnosis of Gastric Cancer" by Drs. Frederic E. Templeton and Richard C. Boyer (*American Journal of Roentgenology and Radium Therapy*, February 1942) is a subject of growing importance with the increase in the span of life. The malignant and degenerative diseases are becoming more noticeable as the average life is prolonged into the seventh decade.

The authors conclude in this article that in most instances a cancer of the stomach that is visible by the new method of gastroscopy is demonstrable by the older method of x-ray and will be diagnosed correctly by both. Gastroscopy has come to stay. The best hospitals of this country are purchasing gastroscopic equipment and training gastroscopists among their gastroenterologists and peroral endoscopists.

The authors state that at times a lesion, by virtue of its location and morphology, is visible only to the gastroscopist or to the x-ray man. Occasionally lesions that are demonstrable by both methods are diagnosed malignant by one examiner and benign by the other. When the facts finally become known it will be found that the gastroscopist is no more or less likely to be correct than is the x-ray man.

Their final statement is that a combination of gastroscopy and x-ray will result in a higher percentage of correct diagnoses than will the use of either procedure alone.—E. M. BLUESTONE, M.D.

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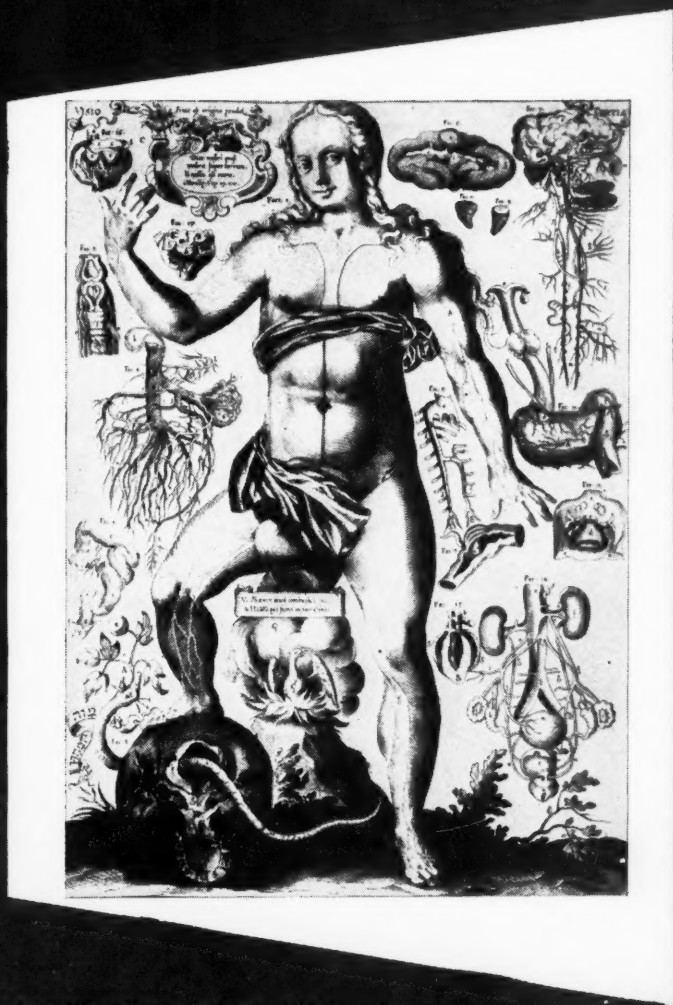
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The "Catoptrum Microcosmicum" is one of the most beautiful and rarest of medical works. This volume by Johann Remmelin, published in 1619, contains fascinating anatomical drawings with superimposed sections. Only three or four copies of the book are known to exist.



Ever Since Eve

woman probably has had to contend with the menopause. Only during a little more than a decade, with the availability of effective drugs—as epitomized by Theelin—has corrective medical treatment been possible.

Theelin replaces or supplements diminishing estrogenic ovarian secretion to "see the patient through" until endocrine readjustment occurs.

Hundreds of published papers pay tribute to Theelin, a pure crystalline estrogen, for meritorious service in such hypogonadal states as the climacteric, senile vaginitis, and kraurosis vulvae; and also gonorrheal vaginitis in children.

Theelin is doubly checked to assure uniform potency . . . by the laboratories of Parke, Davis & Company . . . and the Biochemical Laboratory of St. Louis University.

Theelin Suppositories for vaginal use and Kapseals[†] Theelol for oral administration are supplied for sustained therapy between injections and for patients who travel.

[†]Trademark Reg. U. S. Pat. Off

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This triple-purpose plasma and blood bank is designed to meet the needs of the time, of the nation, of your hospital.

It quick-freezes plasma . . . stores frozen plasma . . . stores liquid plasma and whole blood. It's big. It's automatically controlled. It's equipped to cope with any power failure or other emergency.

Plasma is frozen in three hours by means of blast air at sub-zero temperatures, stored at 0° F. Liquid and frozen storage capacities are optional according to your requirements—that model having the largest frozen storage capacity accommodating approximately 350 bottles of the 300 cc size.

With automatic power failure alarm, hold-over refrigeration facilities, automatic thermal alarm, the Tomac Plasma Bank is equipped for every conceivable emergency.

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News in Review

Hospitals Put in Schools & Institutions Section; Everett Jones Named Consultant

WASHINGTON, D. C.—News for hospitals from this busy spot was more on the good than the bad side last month. Most important was the assigning of all hospitals, voluntary, governmental and proprietary, to the schools and institutions section of the Bureau of Governmental Requirements of the W.P.B. and the engaging of Everett W. Jones as a head hospital consultant in this section to give consideration to the needs of hospitals.

Hereafter, all requests for information and for preference ratings for all hospitals should be sent to the schools and institutions section. This section will make recommendations for denial or approval of applications received from hospitals and, if ratings are recommended, will forward the applications to other interested branches of W.P.B. for concurrence.

In some cases the applications will go to the Health Supplies Branch for attention by Mr. Shields and Milton H. Luce; and it is expected that the Health Supplies Branch will work closely and cooperatively with the schools and institutions section.

New rating systems were announced last month which make the improved ratings given to certain health supplies the preceding month of somewhat less value. All AA ratings were abolished and the following new ratings created: AAA, AA-1, AA-2, etc., all of which take preference over A-1-a ratings.

A sweeping amendment issued July 13 to the iron and steel conservation order (M-126) stops on August 12 the processing of iron and steel for the manufacture of a long list of hospital items. Even the customer is held liable if he accepts delivery of any item which he knows or has reason to believe was fabricated or assembled in violation of this order. Repair and maintenance parts are not stopped, however.

Mr. Luce believes that there are no items on this prohibited list that cannot be made without steel. Other government officials report that, in cases of real need, appeals can be taken and relief will undoubtedly be granted.

Several government officials have expressed the belief that refrigerators especially made for blood bank use could be classed as "laboratory equipment" and thus come under the protection of the Health Supplies Plan.

Production Stopped on These

Anesthesia tables (except for use in operating rooms), arm immersion stands, back rests, basinet stands (except frame), bed cradles, bed feeding and reading trays, bath cabinets (except for hospital use), bedside panel screens, bed trays, blanket warming cabinets, book trucks (except wheel tires), bowl stands (except for use in operating rooms), chairs (other than examining or specialist chairs or dental chairs), chart holders (except necessary hardware), chiropractic adjustment tables, clothes hamper, commodes (except receptacle), couch tables, dish trucks (except wheel tires), dental cabinets, dressing stands.

Dressing carriages (except frame and necessary hardware), examining tables (nonadjustable), ice trucks (except wheel tires), instrument cabinets (except for use in operating rooms), instrument tables (except for use in operating rooms), linen trucks (except wheel tires), laundry trucks (except wheel tires), linen hampers, needle cabinets (except for use in operating rooms), nurses' work tables, orthopedic and fracture carts (except wheel tires and frames), overbed and swing overbed tables.

Record and chart desks and racks, shelf trucks (except wheel tires and frame but not excepting food trucks), solution and irrigator stands (except for use in operating rooms), step-on cans (except receptacle) and mechanism (other than those for use in operating rooms), sterilizer stands (except frame and top), stools (except for use in operating rooms and except mechanism for adjustable stools), supply and treatment cabinets.

Stretchers, wheel type (except wheel tires and frames), adjustable examining tables (except frame and operating mechanism), thermometer baskets, utensil racks, vasoscillator (oscillating beds), wall shelf stands (except for use in operating rooms), and wheel chairs (except essential hardware).

As reported on page 72 of this issue, sterilizers have been one of the most serious bottlenecks among items of hospital equipment. A conference of the industry advisory committee on sterilizers with Army, Navy and W.P.B. officials last month brought improved understanding of this situation. It now seems probable that the industry will be permitted to make enough maintenance and repair parts to keep present sterilizers in operation.

Brother, Can You Spare a Typewriter?

If you have an extra typewriter (standard not portable), Donald Nelson asks you to sell it to your local dealer for use by the government, if it was made since Jan. 1, 1935.

never send a BOY



TO DO A MAN'S JOB

That is the best advice anyone can give today when every job that has to be done IS a man's job. One of the biggest and most important of these new jobs is the conservation of rubber—a real man-sized job if there ever was one. Weak and ineffective efforts are NOT going to be enough. What then can you do to help save rubber? The answer is simple—buy Surgical Gloves of proven quality—Gloves that last longer in active service. We suggest you call for WILTEX or WILCO—the longer lasting CURVED FINGER LATEX SURGEON'S GLOVES.

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There is a growing recognition among hospital managements, doctors and nurses that wards and rooms made colorful and cheerful by Devopake speed convalescence by waking up the will to get well. By the same token, bright, easy-to-clean walls in your service departments build morale and efficiency for all your staff.

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More Liberal Sugar Allotments Are Being Granted to Hospitals

WASHINGTON, D. C.—The sugar situation for hospitals is improving, however slowly. The first allotments of sugar were so low as to imply a discrimination against hospitals. It may be that a 75 per cent allotment will be permitted shortly.

O.P.A. officials have recently declared that they have the welfare of hospitals much at heart. One of the difficulties has been that in consideration of allotments, hospitals and similar institutions have been lumped with restaurants, cafeterias and boarding houses.

In the past month, institutional users of sugar have been permitted to increase their sugar allotments in proportion to an increase in the number of meals they are serving. Special allowances are being made to public and eleemosynary institutions for the canning of fruit. These sugar allowances for canning are made on a basis similar to that granted individual consumers.

The O.P.A. defined public institutions as those that are operated by and receive all or part of their funds from city, county, state or federal sources. These would include state or city hospitals, county homes for the aged and federal veterans' hospitals.

Eleemosynary institutions, as defined by O.P.A., include those that are organized for charitable purposes.

The procedure for handling sugar ration books outlined to the Minnesota Hospital Association is for the following to surrender their sugar ration books to the hospitals: (a) all employees eating all of their meals in the institution; (b) all employees eating 12 or more meals per week in the institution and the remainder in public eating places, and (c) patients who have been in the institution for more than ten days. Employees who eat 12 or more meals in the institution but also prepare meals in their own homes will retain their books.

As ration stamps come due the hospital should deduct these from the books in its possession and surrender them to the local rationing board for cancellation.

One M.D. for Every 1500 Is Minimum

One "effective" physician for every 1500 persons is the minimum coverage that should be provided, pending the completion of special studies now under way, it has been agreed by the board of Procurement and Assignment Services for Physicians, Dentists and Veterinarians. Limited specialists are not included in the foregoing basic figure.

CARRIER BLOOD BANK

**Serves Red Cross Blood
Donor Center in Chicago**

DEPENDABLE refrigeration is an important factor in the proper preservation of whole blood before processing into dried plasma. That's why the American Red Cross selected Carrier refrigeration for the Blood Donor Center recently opened at 624 South Michigan Avenue in Chicago. Blood donated by patriotic Chicagoans to the plasma reservoir is preserved in the specially designed Carrier electric refrigerator at a temperature of $+4^{\circ}\text{C}$ until it is shipped to the laboratory for processing into dried plasma.

If your hospital is planning a blood or plasma bank, Carrier can supply the correct equipment to meet your requirements for freezing blood at -20°C , low temperature storage for frozen plasma at -10°C or storage of liquid plasma or whole blood at $+4^{\circ}\text{C}$.



★ 200 PINTS OF WHOLE BLOOD can be stored in this huge Carrier Electric Refrigerator at the American Red Cross Blood Donor Center in Chicago. A special auxiliary device assures maintenance of temperature necessary to preserve blood until it is shipped to laboratories for processing into dried plasma.



The Navy "E", one of the U. S. Navy's most coveted honors, has been awarded to CARRIER for excellence in war production.

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Please send information regarding Carrier refrigeration equipment for plasma and blood banks.

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Reference List of Official Orders

(Issued between June 15 and July 15)

WASHINGTON, D. C.—Many War Production Board orders of importance to hospitals were issued during the past month. For ready reference by administrators and purchasing agents they are tabulated alphabetically as follows:

Air Conditioning Machinery and Equipment.—Amendment 1, issued June 18, to Order L-38, Industrial and Commercial Refrigeration, affords manufacturers and distributors some relief from its provisions. Order L-126, effective July 6, re-

quires reduction in sizes and types of the common drinking water coolers and refrigeration condensing units used for various commercial and industrial purposes. Amendment 2, July 6, to Order L-38 clarifies restrictions on the sale of water coolers. (See under Refrigeration also.)

Antimalarial Agents.—Amendment 1, issued June 19, to Order M-131 and M-131-a is designed to prevent use of stocks of antimalarial drugs for nonessential purposes.

Arsenic.—Amendment 1 to Order M-152 simplifies the procedure by which users of small amounts of arsenic may place purchase orders.

Chemicals.—Order M-19-a, effective July 6, places under complete allocation control the entire supply of high test calcium hypochlorite and chloride of lime. This order ensures adequate supplies of these chemicals for civilian defense gas decontamination and for essential uses of the Army and Navy.

Cocoa Bean Quota.—Order M-145-b, issued June 25, makes a 14 per cent reduction from the present quota of cocoa beans that may be processed for the quarter beginning July 1.

Construction.—A large group of slow-moving, noncritical building materials have been specifically released from Order L-63 by Exemption 5, effective June 23. Among others are insulation board, acoustical materials, mineral wool, glass, lumber and wooden mill work.

Orders P-19-a and P-19-h, under which builders and contractors have been able to get preference ratings on materials for entire projects with one application, were amended July 7 to include certain "expendible materials" consumed in the construction of the projects. Amendment 1 to P-19-h permits builders operating under P-19-a and P-19-h to use preference rating assigned by order to obtain expendible items which are not actually incorporated in the project.

Order L-121, amended July 10, extends the softwood construction lumber freeze until August 13 to provide sufficient time for development of a system of distribution based on the relative essentiality of lumber for war purposes.

Copper.—Amendment 2, issued June 17, to Order M-9-c revises restrictions governing use of copper and brass in certain civilian products. The use of zippers, snappers, fasteners and other copper and brass findings is permitted, but none may be manufactured.

Dental Drills.—Order L-139, issued June 25, requires a reduction in sizes and types of dental excavating burs.

Electric Lamps and Shades.—Amendment 3, issued July 13, to Order L-33 permits manufacturers of portable lamps and lamp shades to use up their existing supplies of fabricated or semi-fabricated metal, metal parts, lamp cords and silk.

Elevator Equipment.—Order L-89, effective July 9, establishes rigid control over manufacture and delivery of elevator equipment and certain types of elevators.

Fire Protective Equipment.—Order L-39, as amended July 11, places further restrictions on manufacture of fire protective equipment.

Laundry Equipment.—Order L-91, as amended to June 22, was reissued. The order controls production and distribution of laundry and dry-cleaning equipment and tailors' pressing machinery.

Metal Office Furniture.—Amendment 3, issued July 3, to Order L-13-a rules that metal office furniture producers may now accept only those orders specifically authorized by W.P.B.

Repainting.—Repainting and redecorating without specific authorization are permitted under the terms of Order L-41 when they constitute maintenance or repair.

Refrigeration Repair.—Amendment 1, effective June 30, to Order P-126 extends high preference ratings for deliveries of materials needed for emergency repairs to commercial air-conditioning and refrigeration equipment.

Rubber.—Order M-174, effective June 24, limits use of elastic fabric to essential health articles and to military products. Amendment 1, issued June 27, lifts restrictions on elastic fabric unsuited for health purposes. Order L-137, effective June 18, restricts use of elastic fabrics in the manufacture of sanitary belts, sanitary crotch shields and athletic supports and suspensories.

Spice.—Monthly clove quotas for food processors, manufacturers of medicines and clove packers are increased by one third and for other manufacturers and wholesale receivers are doubled by Amendment 1, effective July 1, to Order M-127-a as amended.

Steel.—Order M-126, as amended July 13, prohibits the manufacture of an additional long list of civilian articles. (See news story in this issue.)

Amendment 2, issued July 3, to Order L-49, announces limitations on the manufacture of beds, springs and innerspring mattresses. Hospitals are exempt from this order.

Amendment 4 to Order L-30 extends restrictions on the use of iron, steel and zinc in household and other miscellaneous articles. Amendment 2, is-



It Cleanses. It Lubricates ...in one simple bathing

YOUR nurses cut infant bathing time in half when they use Baby-San, for Baby-San eliminates the need for oiling the infant's skin. In short, the Baby-San bath is a complete bath, requiring no additional lubricants.

This purest liquid castile soap contains the highest possible concentration of top-grade oils. Hence, as Baby-San cleanses, it also lubricates... leaves a safety film of oil to keep the skin free from superficial dryness or irritation. That's why a Baby-San bath leaves the baby soothed... comfortable.

You can buy no purer or more economical soap than Baby-San—the choice of 65% of the nation's nurseries.

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THE BABY-SAN DISPENSER

The Baby-San Portable Dispenser holds one pint. Dispenses just the right amount of soap, thus preventing waste. Easily sterilized and weighted so that it cannot tip over. Dispenser furnished free to quantity users of Baby-San.

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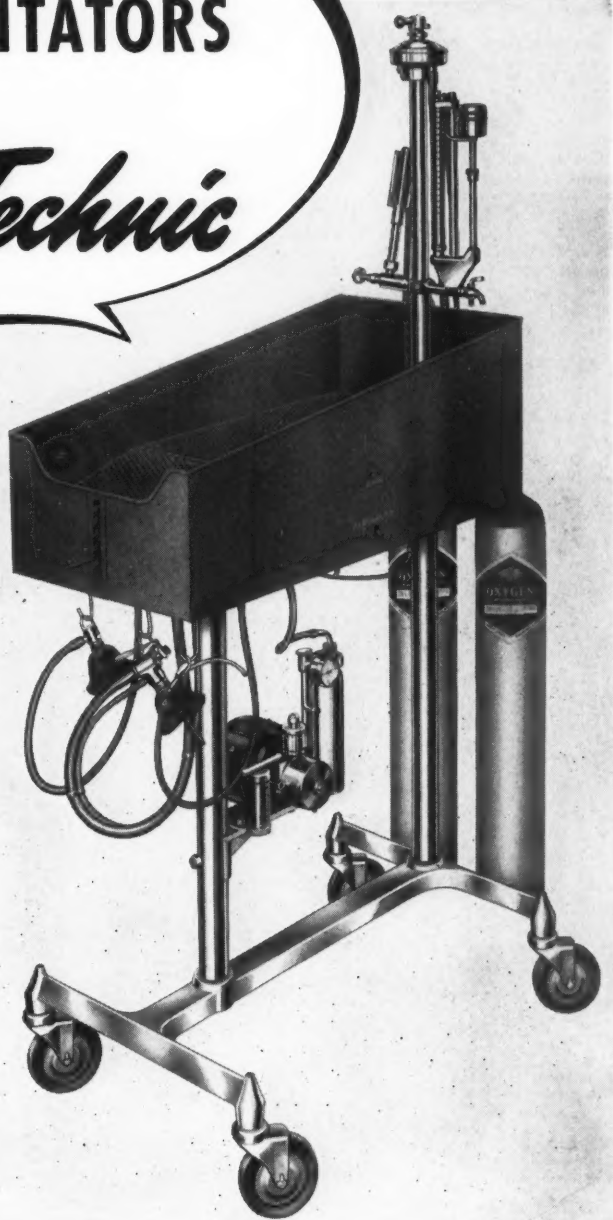
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Simple, Safe Technic

Heidbrink Resuscitators are of two general types—one designed especially for use on new-born and very small infants; the other for use on older children and adults. Technic for using either size is simple and safe. On models for infants the operator merely adjusts the automat to deliver the pressure selected for the type, size and age of patient, adjusts the escape valve of the water manometer and administers Oxygen rhythmically to simulate natural breathing. When breathing begins, Oxygen or Oxygen-air mixture is administered continuously. With adult models, the automat is set to deliver the selected pressure and the same technic applied as with models for infants.

Stand Models for Adults

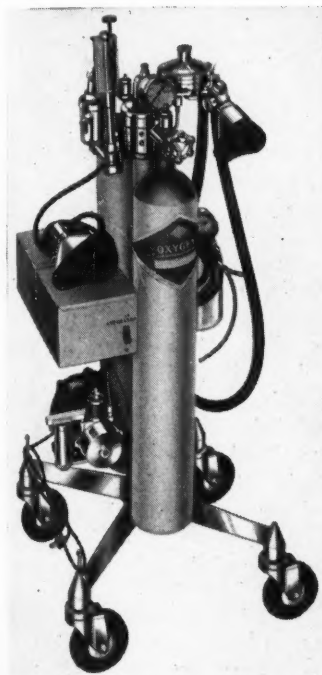
Model 51A Heidbrink Adult Resuscitator includes operative head complete with calibrated automat, flowmeter calibrated for Oxygen and 80-20 percent Helium-Oxygen mixture, two-yoke automatic regulator for D and E size tanks, 3,000-lb. tank pressure gauge, resuscitation and inhalation inhalers with adult size interchangeable bodies, adult size catheter adapter, tubings, hand-wheel wrench. Complete equipment is mounted on a four-caster stand.

The "Accepted" seal denotes that Heidbrink Resuscitators, Models 51A and 20A, have been accepted by The Council on Physical Therapy of The American Medical Association.



Bassinet Model for Infants

Model No. 20A for resuscitation, inhalation and aspiration. Includes operative head with automat, manometer and flowmeter, two-yoke automatic regulator for D or E size gas tanks, electrically warmed bassinet with large drawer, perforated tray adjustable up and down at both ends, mattress, electrically operated aspirator, infant size resuscitation inhaler with airway, infant size inhalation inhaler, infant size catheter adapter and intratracheal catheter, tubings, handwheel wrench. Complete for use, mounted on heavy two-post stand with large noiseless casters.



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sued June 26, to Order M-126 effected changes in coffee roasting machinery.

Tea and Coffee.—Amendment 1 to M-111 (tea) and amendment 3 to M-135 (coffee) allow public institutions to obtain their coffee and tea requirements.

Tin and Terne Plate.—An amended version of Order M-21-e permits tin and terne plate which have been put in process on May 16 and roofings, furnace pipes and fittings in inventory on May 16 to be used in repairs, regardless of ratings.

Typewriters.—W.P.B. issued July 1 an interpretation to clear up definitions in Order L-54-a regulating production and distribution of typewriters.

Venetian Blinds.—Amendment 3 to Order L-62 permits manufacturers to assemble fabricated metal parts (on hand as of March 20) until September.

Don't Delay Registering Your Diathermy Machine

WASHINGTON, D. C.—In answer to the order for the registration of diathermy machines, applications have reached almost 70,000 to date.

The Board of War Communications (formerly Defense Communications Board) deems this number a fairly satisfactory record, especially since applications continue to arrive. The impression persists, however, that substantial numbers of additional machines are still unregistered. The board urges prompt action.

Hospitals Rank High on War Construction Priority Certificates

WASHINGTON, D. C.—Full speed ahead for the \$300,000,000 war public works program was the schedule announced on July 9 by Brig. Gen. Philip B. Fleming, Federal Works administrator, on behalf of his agency and the W.P.B.

Projects must be essential to the war effort, unable to be postponed, unable to be replaced by rented or converted existing facilities, not duplicating or unnecessarily expanding existing facilities, embodying all possible economies, of the simplest type and have available sufficient labor and public utilities to make operation feasible.

Hospitals occupy a high position on the list of projects that will be aided by effective priority certificates and allocation of necessary materials. For hospitals, health centers, schools and recreational facilities, the Federal Security Agency will advise with the Federal Works Agency as to the importance of the projects.

Must Recruit Doctors at Rate of 100 Plus per Day

WASHINGTON, D. C.—The Army during July was preparing to enroll 20,000 additional doctors by January 1. To reach this goal doctors must be recruited at the rate of more than 100 a day. Medical Department Officers' Recruiting Boards have been set up in the states to interview physicians, check their credentials, give final physical examinations, and issue or recommend commissions for properly qualified applicants.

A communication from Col. Sam F. Seeley says that a recent decision of the War Department provides "that graduates of certain medical schools in the United States not meeting all the requirements of the Council on Medical Education, but who it is believed meet sufficient requirements to warrant graduates thereof being given commissions, may be tendered temporary appointments in the Army of the United States" under certain restrictions. The Surgeon General determines whether or not the graduate of the school in question is eligible.

Extension on Instrument Replating

WASHINGTON, D. C.—W.P.B. last month granted a 90 day extension from July 15 for the use of chrome and nickel for plating in the manufacture and repair of surgical instruments. Hospitals that have instruments that need replating or repair should take care of this immediately. Meanwhile the search for satisfactory substitute materials is being continued.



Confidence in the Ultimate Result

Is assured by the use of the E & J RESUSCITATOR. There are seventeen years of success in the most desperate cases of asphyxia behind each E & J apparatus. This assurance of success has served to eliminate the fear of Asphyxial Death in more than 1000 leading clinics. The E & J Resuscitator is designed and built by the Pioneers and Specialists in Mechanical Artificial Respiration.

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Absence of Acetone in U. S. I. Alcohol

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Not only is the most careful manufacturing control exercised to obtain highest purity in the production of U. S. I. Pure Alcohol, but the finished product undergoes a series of thorough tests that assure freedom from all harmful impurities. For example, U. S. I. Pure Alcohol must meet U. S. P. standards for freedom from acetone. For this purpose, it is subjected to the following test: 3 cc. of distilled water and 10 cc. of mercuric sulfate test solution are added to a mixture of 1 cc. of alcohol and 1 cc. of distilled water. This mixture is heated on a bath of boiling water. If no precipitate forms within three minutes, the alcohol is considered free from any harmful quantities of acetone.

There can be no compromise with purity in the alcohol used for floor dressings and packs. In U. S. I. Pure Alcohol, doctors and nurses have found an alcohol with exceptional purity, one that can be unquestionably relied upon for hospital use. U. S. I. Pure Alcohol undergoes such rigid tests that it not only equals, but exceeds U. S. P. standards for purity. That is why it is used with utmost confidence in leading hospitals throughout the country for every application. Such extra care in testing is your guarantee of an alcohol to meet the most exacting needs. Benefit from the unusually high qualities of U. S. I. Pure Alcohol by using it in your laboratory, operating room and pharmacy.

Check your requirements for alcohol with this convenient list of 21 major hospital applications...and specify U.S.I. Pure Alcohol for every use.

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| <input type="checkbox"/> Duodenal Drainage | <input type="checkbox"/> Spirit Lamps |
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| <input type="checkbox"/> Hypodermic Injections | <input type="checkbox"/> Surgical Soap Preparation |
| <input type="checkbox"/> Massage and Sponge | <input type="checkbox"/> Sutures Sterile Solution |
| | <input type="checkbox"/> Therapeutic Nerve Block |

Relative Rank Is Granted to Navy Nurse Corps Members

WASHINGTON, D. C.—Recently enacted legislation prescribes the relative rank of members of the Navy Nurse Corps in relation to commissioned officers of the Navy.

Hereafter, the superintendent will have the relative rank of lieutenant commander; the assistant superintendents, not to exceed one for each 300 members of the Navy Nurse Corps, the relative rank of lieutenant; chief nurse, the relative rank of lieutenant (junior

grade); nurses, the relative rank of ensign.

A bill up for consideration concerns an increase in the pay and allowances of the members of the Army Nurse Corps. The idea is to make the pay of Army nurses equivalent to that of officers in the Army.

A bill for the creation of medical academies is now pending. The bill states that "there shall be created in each corps area of the United States, as now constituted, a medical training school for the instruction of physicians for the armed forces and Public Health Service."



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HOME TO START the life-time job of being Dad and Mother to formulas and diapers and work and unexpected pangs of ecstasy

Home to unbelieving pride the day he walks the day they're sure they understand his moist sweet garbled sounds to moments of half-vexed smothered laughter as he craftily explores the tender limits of his father's temper.

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Another bill authorizes an appropriation to provide additional hospital and out-patient dispensary facilities for persons entitled to hospitalization in Veterans' Administration facilities.

O.C.D. Appoints State Hospital Officers for 13 States and Regions

WASHINGTON, D. C.—The medical division of O.C.D. announces the appointment of state hospital officers in coastal states to direct the hospital program of the Emergency Medical Service under the state chiefs of E.M.S. The following have received full-time civil service appointments in the U. S. Public Health Service for these positions:

California: Thomas F. Clark, executive secretary, Association of Western Hospitals, San Francisco.

Connecticut: William B. Sweeney, administrator, Windham Community Memorial Hospital, Willimantic.

Massachusetts: Oliver Pratt, administrator, Salem Hospital, Salem.

Pennsylvania: Maj. Roger A. Greene, administrator, Pottsville Hospital, Pottsville.

Virginia: M. Haskins Coleman, secretary, Richmond Hospital Service Association, Richmond.

Fourth Civilian Defense Region: John W. Rankin, Durham, N. C.

The following hospital officers have been appointed consultants in the U. S. Public Health Service for part-time duty:

Maine: G. K. Lermond, Thomaston.

Maryland and District of Columbia: J. Douglas Colman, executive director, Associated Hospital Service of Baltimore.

New Hampshire: Donald Steel Smith, administrator, Mary Hitchcock Memorial Hospital, Hanover.

New Jersey: Emil O. Frankel, division of statistics and research, State Department of Institutions and Agencies, Trenton.

Oregon: Ralf Couch, chairman, Hospital Service Council, Portland.

Rhode Island: Dr. George Matteson, general surgeon, Providence.

Vermont: Laurence Campbell, hospital trustee, Barre.

These hospital officers will survey rural facilities suitable for use as emergency base hospitals; supervise personnel arrangements for the base hospitals and reception centers for evacuated civilians; collaborate with state chiefs of the E.M.S. in controlling movements of medical and nursing staffs as well as of casualties in any situation affecting emergency base hospitals, and perfect arrangements for transporting patients evacuated from casualty receiving hospitals.



QUESTION: *How would canned infant and junior foods be of value in the feeding program of my baby?*

ANSWER: Well. The wide variety of available pureed and chopped foods serve as convenient means for the development of good eating habits. The gradual introduction in the diet of the infant of the various "protective foods" in the strained form assists in cultivating a taste for these foods. The chopped foods afford a means of smooth transition from the finely divided foods, which are suitable for the young infant, to the vegetables, fruits, meats, and cereals in the coarse forms as they appear in the diets of the older child and adult.

In addition, the inclusion of such canned foods in the diet of the infant supplements the milk formula with respect to vitamins, minerals, and non-digestible materials which increase the bulk of the intestinal residue (1).

American Can Company, 230 Park Avenue, New York, N. Y.

- | | |
|--|---------------------------------------|
| (1) 1938, Am. J. Diseases Children 55, 1158. | 1940, Calif. and Western Med. 53, 18. |
| 1939, Hygeia 17, 171 | 1941, J. Am. Dietet. Assn. 17, 861. |
| 1941, Arch. Pediatrics 58, 40. | |



The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

Hospital Scrap Rubber Is Best, Says Government Bureau Chief

WASHINGTON, D. C.—An urgent appeal to hospitals to save all possible scrap rubber, particularly rubber gloves, was voiced last month by the Rubber and Rubber Products Branch of W.P.B.

"The quality of reclaimed rubber is directly dependent on the quality of rubber scrap. The scrap obtained from hospitals is of the highest value and, in some respects, superior to old tires and tubes," according to H. S. Rogers, chief of the bureau.

"Not only should worn articles be saved but, when practical, they should be re-used until entirely worn out. Gloves, for instance, when some slight injury occurs should be repaired and re-used in appropriate places."

Mr. Rogers requests hospitals to save everything made of rubber: gloves, medicine stoppers, tubing, sheeting, adhesive tape, elastic bandages, supporters, hot water bottles, ice caps, mats, matting and similar articles.

The attending medical staff should also be asked to save rubber in office practice. When the quantity is insuffi-

cient for collection of individual savings, the doctors should be asked to bring their accumulations to the hospital.

Waste rubber should be sterilized before it leaves the hospital and should be so marked.

O.C.D. Names Consultants on Blood and Plasma Banks

WASHINGTON, D. C.—The following regional consultants have been appointed under the program launched by the medical division of O.C.D. and the U. S. Public Health Service to advise hospitals on technical problems related to the establishment of blood and plasma banks: Dr. Fred Bryan, Rochester, N. Y., for the first and second civilian defense regions and a part of the third; Dr. John Elliott, Salisbury, N. C., for the fourth and eighth regions and the remainder of the third, and Dr. Emeric Dobbs, senior surgeon (R), U. S. Public Health Service, for the ninth region. Dr. Elmer L. DeGowin, Iowa City, is acting as technical consultant on special problems.

Dr. David D. Rutstein, chief of the cardiac bureau of the New York State Department of Health, Albany, has been appointed to the staff of the medical division, O.C.D., Washington, D. C., as medical gas officer to organize instruction for physicians of Eastern States in the medical aspects of chemical warfare.

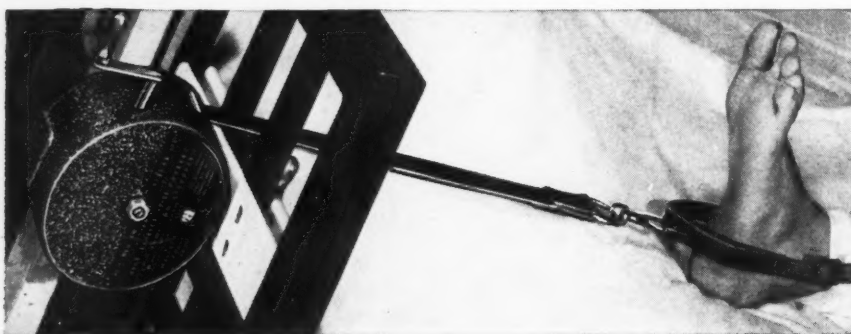
Dr. Fred T. Foard, surgeon, U. S. Public Health Service, has been assigned as regional medical officer for the ninth civilian defense region with headquarters in San Francisco.

Why General Duty Nurses Flee From Hospital Work

WASHINGTON, D. C.—Inadequate and outdated personnel policies are held to be playing a part in the difficulties that hospitals are having in obtaining adequate graduate nurses for general duty, according to a statement issued jointly by the subcommittees on hospitals and on nursing of the health and the medical committee of the Office of Defense Health and Welfare.

The statement, released June 29, declares that many graduate nurses are being attracted into other occupations because of more desirable employment and salary conditions and that it is becoming increasingly difficult to attract well-qualified young women into schools of nursing because of the competition with other fields.

The subcommittees, therefore, recommend that hospital authorities study the revised edition of the "Manual of the Essentials of Good Hospital Nursing Service," published jointly by the A.H.A. and the N.L.N.E.



A NEW REEL FOR SURGICAL TRACTION

The Herzmark-Adams power spring traction apparatus can be used for all types of traction where pulleys and weights are now used. This includes skin or pin traction, skull traction, overhead traction from a frame, as well as counter traction. A removable key adjusts the traction to up to twenty pounds. A scale shows the number of pounds used. The apparatus is easily attached to any position on the bed, using only the attachments supplied.

NOTE: The elimination of swinging weights makes this apparatus ideal for use on board ship, train, plane, or car.

FEATURES . . .

1. No weights to handle. Traction up to 20 pounds set by the removable key. The apparatus is self-contained.
2. It provides constant traction since the weights are not bumped into and cannot become caught. Once the traction is adjusted and the key removed, visitors cannot change the adjustment.
3. Movement of the patient causes practically no variation in traction.
4. Easily attached with only the attachments supplied.
5. The apparatus is durably built . . . there is nothing to get out of order.

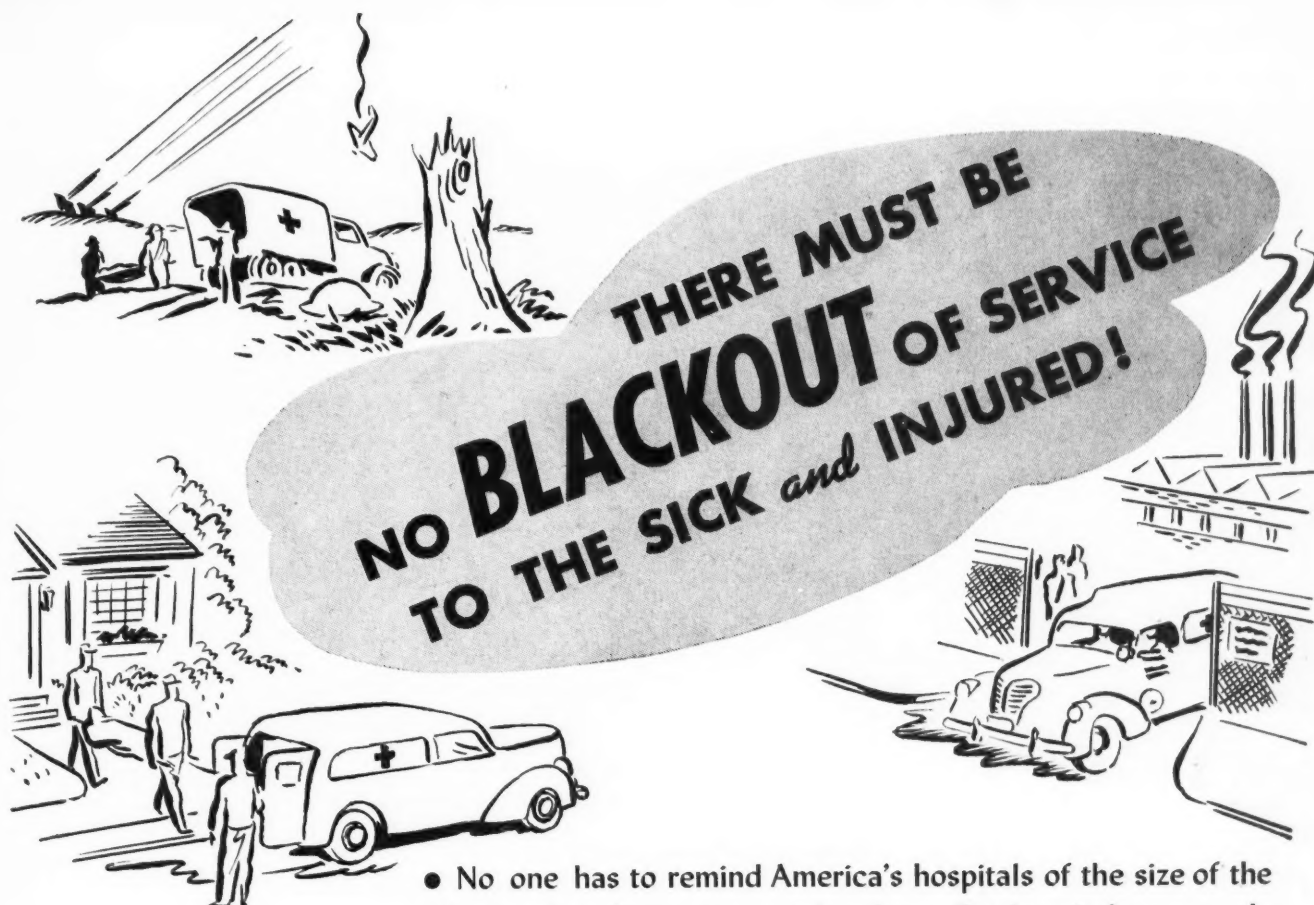
No. B-1000 Herzmark-Adams Traction Reel with two 12" horizontal bars and one 14" vertical extension bar . . . \$34.50.

Discounts for quantity. Prices higher outside U. S. A.

CLAY-ADAMS CO. INC.

44 EAST 23rd STREET, NEW YORK, N. Y.





• No one has to remind America's hospitals of the size of the job that has been cut out for them. But hospitals are made of the stuff that can "take it", no matter how tough the rules and handicaps ...and come out on top. While the bulk of the burden falls on the hospitals themselves, this is a job to which many strong shoulders outside of the hospitals, are lending their willing support. . . . Less obvious and less dramatic than the actual care of the sick and injured is the task of maintaining a flow of needed supplies and equipment . . . without which the modern hospital cannot function. Many heads and many shoulders in many fields, are dedicated to this task — so that *there shall be no blackout of service to the sick and injured.* . . . Working together in close unity and with a wholesome sense of mutual helpfulness and understanding, hospital executives, and manufacturers and suppliers, are accomplishing wonders. Hospital problems *are* being met...and will continue to be met. It is a privilege to have a part in this great work.

WILL ROSS, Inc.

QUALITY HOSPITAL SUPPLIES

MILWAUKEE

WISCONSIN



No More Morning Visitors

No morning visiting hours for Rhode Island hospitals was the recommendation made by the Hospital Association of Rhode Island recently to trustees of all hospitals in the state. Visiting hours for all types of patients should be limited to set hours between 1 and 9 p.m., the period being left to the discretion of the individual hospital. Visitors during morning hours have been found detrimental to the patients' recovery and have embarrassed the nursing service to an extent to give concern during these times of depleted nursing staffs. Hospi-

tals of the state plan to announce their revised regulations on August 1.

Johns Hopkins Gets Large Grant

The National Foundation for Infantile Paralysis, Inc., announced on July 13 a five year \$300,000 grant to Johns Hopkins University, for an intensive and long time study of the disease. Checks totaling \$325,844.25 have been mailed to 26 other institutions to carry on research work on the virus and after-effects of the disease. These funds are raised annually in January during the various celebrations of the President's birthday.

Finds Hospital Liable for Damages Caused by Negligence of Employee

WASHINGTON, D. C.—The U. S. Court of Appeals has ruled that hospitals and charitable organizations can be forced to pay damages in suits involving negligence by their employees while on duty. The case appealed was that of a private duty nurse struck in the back by a door carelessly flung open by a student nurse at Georgetown University Hospital, Washington, D. C. The injured nurse received a jury verdict in her favor in April 1940.

The lower court had overruled a contention by the hospital that, under a century-old legal practice, charitable institutions are immune from damage suits brought by persons not connected with them. The U. S. Court of Appeals in July 1942 upheld the district court award of \$20,000 to the special nurse. In a twenty-three page opinion it held there should be no distinction between the liability of charitable organizations and that of individuals.

The court added: "It is a strange distinction . . . relieving the one, holding the other for like service and like lapse in like circumstances. The hospital may maim or kill the charity patient by negligence, yet the members of its medical staff, operating or attending without pay or thought of it dare not lapse in a tired or hurried moment. The institution goes free. The physician pays. Yet they render a common service which the hospital could not furnish without him."

Flint-Goodridge Again Will Train Nurses; Also Midwives

Flint-Goodridge Hospital of Dillard University, New Orleans, is planning to reopen its nursing school, probably on a five year basis using jointly the facilities of the university, the hospital and also Charity Hospital. Students will probably be admitted in September.

On August 15 a school of nurse-midwifery is to be opened, modeled somewhat on the Lobenstine Clinic in New York. It is expected that these Negro graduate nurse-midwives will work in rural areas under the supervision of county health units.

Gets \$10,000 From Former Patient

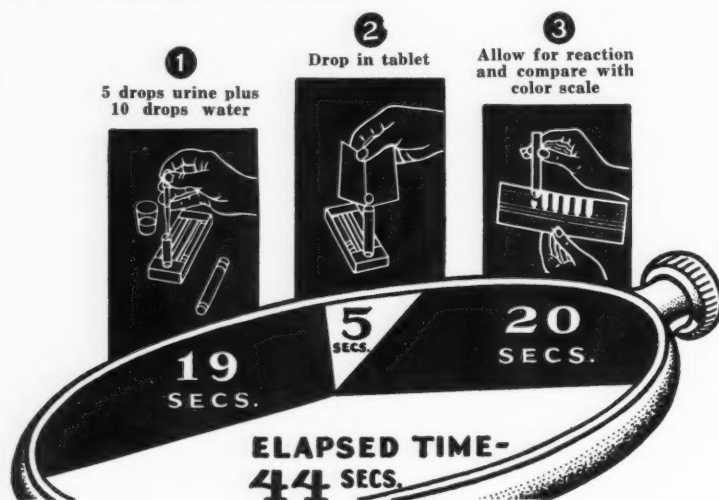
A bequest of \$10,000 to the Lutheran Hospital Society of Southern California for the benefit of the endowment fund of Santa Monica Hospital is announced by Ritz E. Heerman. On three occasions the donor, Mrs. Joanna Blanche Brill, had been a patient in the hospital while in summer residence in Santa Monica.

URINE-SUGAR TESTING BECOMES A MATTER OF SECONDS WITH...

CLINITEST

The New Tablet Method

JUST 3 SIMPLE STEPS:



DEPENDABLE RESULTS—Clinitest Tablet Method is based on same chemical principles involved in Benedict's test—*except*—no external heating required, and active ingredients for test contained in a single tablet. Indicates sugar at 0%, 1/4%, 1/2%, 3/4%, 1% and 2% plus.

Clinitest is adapted to mass laboratory testing. Combines maximum efficiency with speed of operation.

Write for full descriptive literature on Clinitest Urine-Sugar Analysis Set and economical Laboratory Unit.



EFFERVESCENT PRODUCTS, INC.
ELKHART, INDIANA



FOUR CLEANERS IN ONE BARREL

WHEN the barrel was full it contained an all-around, low-cost, free-rinsing cleanser—able to handle the four major cleaning and washing operations in your building.

1. **Wyandotte Detergent** makes painted surfaces come clean. A regular use of it keeps walls and ceilings bright and fresh, lengthens the time between paintings.

2. **Wyandotte Detergent** is un-

excelled for mopping or scrubbing floors. A little goes a long way to keep the floors spick and span but not slippery. 100 square feet can be cleaned *for a year* at a material cost of less than \$1.

3. **Wyandotte Detergent** is safe as well as efficient. It does not harm porcelain enamel surfaces. Quickly, easily, economically it will clean the washbowls in your building. (230

very dirty washbowls can be cleaned for only 7c!)

4. **Wyandotte Detergent** has special value as a poultice on stained marble. It draws the stains right out. Low in cost. Easy to use. Ask for full directions.

Your Wyandotte Service Representative will be glad to show you how this one cleaner can solve most of your maintenance cleaning needs.



THE J. B. FORD SALES CO., WYANDOTTE, MICHIGAN

Possible Tax Relief for All Hospitals in District of Columbia

WASHINGTON, D. C.—A group of lawyers of the District of Columbia Bar Association is now preparing a bill that will shortly be presented on the floor of the House of Representatives. Representative Hunter, chairman of the fiscal affairs subcommittee of the House district committee, will introduce the bill, the purpose of which is to give tax relief to hospitals, charitable, patriotic and educational institutions. These institutions in the District of Columbia

have recently been placed on the tax rolls by the district commissioners under strict interpretation of old tax laws.

Representative Hunter declared that he was impelled to take this action because of many protests from institutions recently denied exemption. The District Bar Association will study and report on institutional tax laws and exemptions in various states. Mr. Hunter believes that most states exempt hospitals and educational buildings from taxation and are more lenient to charitable institutions than is the District of Columbia.

Charitable institutions operated "without charge to inmates" and without

profit or income are exempt under the district tax laws, as are educational buildings "not used for private gain." Mr. Hunter feels that this is too strict a limitation. He says the bill about to be introduced will be subject to amendment and revision, but he hopes to get it through in as short a time as possible.

More Nurses' Aides Needed; Red Cross Relaxes Regulations

WASHINGTON, D. C.—A recent report shows that 25,905 nurses' aides have been enrolled and more than 12,000 have been certificated. Though training has been well carried out and nurses' aides are now giving valuable service, the number falls far short of the goal of 100,000 set in the beginning of the campaign. O.C.D. urges a concerted effort to stimulate the recruitment and enrollment of aides to relieve the serious shortage of nursing personnel in hospitals.

Considerable concern has been manifested over the reports that some hospitals have accepted volunteer workers and permitted them to carry out many of the tasks usually performed by nurses' aides. A memorandum from the Medical Division of the O.C.D. to regional medical officers points out the danger of allowing untrained workers to give service to patients and the handicap to recruitment of students for the nurses' aide course.

The Red Cross recently modified its requirements that all hospitals selected as training centers for nurses' aides must be on the approved lists of the American Medical Association and the American College of Surgeons. If the nursing standards are high, if the hospital in question is not on the approved list because of lack of equipment (having no connection with training of nurses' aides) and if the area Red Cross nursing supervisor confirms the recommendation of the local committee, the hospital may be approved as a training center.

Changes Name Before Drive for Funds

As the initial step of its first appeal to the public for financial support, Rockford Hospital, Rockford, Ill., a 59 year old institution, changed its name to the Rockford Memorial Hospital, because many persons believed the hospital to be city owned and supported by tax funds. The \$300,000 campaign for additional plant and equipment was concluded in mid-June with subscriptions amounting to \$326,499. There were four gifts of \$25,000 each. The appeal was made to persons who could contribute at least \$100. Ketchum, Inc. of Pittsburgh organized and conducted the drive.



A New Value Every Hospital Wants! The "Individual Care" Bassinet Stand

\$29.95 Filling modern demands for individual infant equipment at a new low cost, this stand has proved a hospital hit. At a recent meeting, its first showing brought instant sales in quantity. It's priced at just about half what you'd expect to pay, allowing more infants to have this modern benefit. The frame is made of sturdy steel tubing, the entire bassinet stand welded into a solid whole. A basin ring is located in the left compartment. A sliding tray for the infant is 22½ x 13⅞ inches. Ample room is provided for storage of blankets and other supplies.

JP9293—"Individual Care" Bassinet Stand, standard size with Bassinet, on 2-inch casters.....\$29.95

SHARP & SMITH HOSPITAL DIVISION

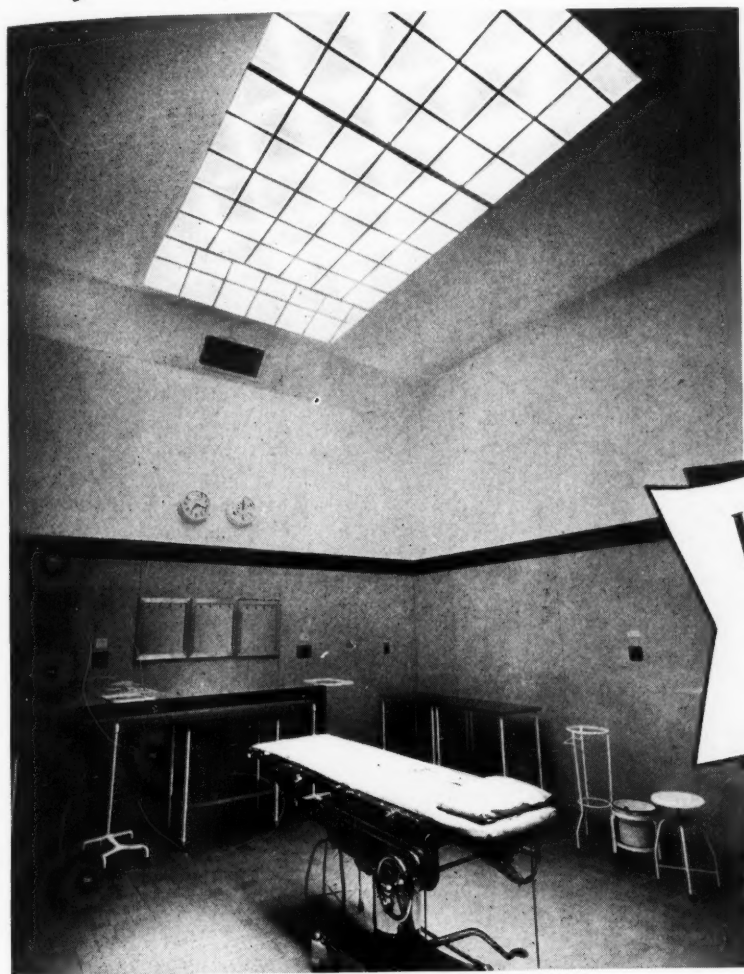
A. S. ALOE COMPANY

1831 Olive Street

St. Louis, Missouri



Lighting for Surgeries Must be the Best that Science Can Provide



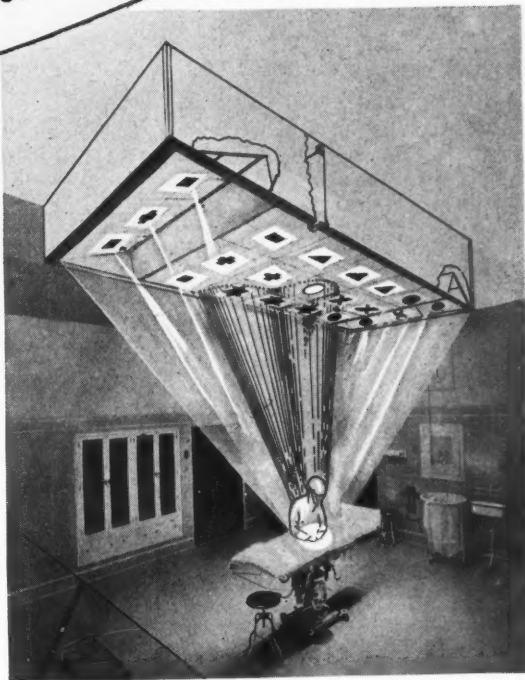
The finest professional skill and instruments are summoned to the critical needs of the operating room . . . The lighting equipment must be comparable to this standard. Illumination produced by the Multiple Controlens System (M.C.L.S.), product of Holophane Research, is widely recommended for today's surgeries because it is the most effective, permanent lighting equipment available for the purpose.

HOLOPHANE M. C. L. S.
(MULTIPLE CONTROLENS SYSTEM)
LIGHTING for MODERN SURGERIES

ADVANTAGES of the HOLOPHANE Multiple Controlens Lighting System

- It provides correct scientific visual conditions throughout the operating room . . . Without glare, shadows or surgeon's discomfort (see diagram at right)
- It blankets all the operating positions that other systems can reach only by movement. It leaves the surgeon free to operate in any position
- Its "built-in-ceiling" arrangement places the light sources outside the zone of explosion or mechanical hazard
- It minimizes danger of light failure or interruption—15, 18 or 21 lamps in each M. C. L. S. installation

Lighting requirements for operating rooms will vary according to type, specialization, or architectural construction . . . The Holophane Engineering department will be glad to provide consultation and specific recommendations for efficient, economic lighting without obligation . . . Write for new Bulletin giving essential data on Operating Room Illumination.



Holophane surgery systems are especially wired so that surgeon can operate from any one of four principal positions with speed, confidence and comfort . . . Lights that would be blocked by the surgeon's body and heat his back and neck do NOT come on. Remaining lights are designed for full spot intensity and gently warm the area of the incision.

Holophane
COMPANY, INC. Lighting Authorities—Since 1898

342 MADISON AVE.
NEW YORK CITY

THE HOLOPHANE CO. LTD
385 YONGE ST. TORONTO, CAN.

Hospital Will Train Nursery Maids as Contribution to War

To meet the urgent need for trained workers in child care resulting from mothers entering war industries, Michael Reese Hospital, Chicago, is offering a one year course for nursery maids.

Since the responsibility of nursery maids is the care of well children, a one year course is deemed sufficient. It includes instruction in child hygiene, laundry work, mending, sewing, simple nursery emergencies, infant feeding and the rudiments of kindergarten work.

Young women between the ages of 18

and 30 having two or more years of high school education are eligible. Board, room and laundry are supplied by the hospital. These women are expected to command salaries of from \$18 to \$20 a week upon completion of the course.

No Interns on Ambulances

Thirty-four voluntary hospitals of New York City have followed the lead of the city-owned institutions in taking interns off ambulances and replacing them by trained attendants, according to a recent report by Bernard McDermott, president of the Greater New York Association.

Rorem to Puerto Rico for Blue Cross; Other Plan News

C. Rufus Rorem, director of the Commission on Hospital Service, went to Puerto Rico in late July for a conference with Gov. Rexford Guy Tugwell and leading hospital and medical authorities to aid them in establishing a low cost hospital service plan on the island.

Meanwhile, at home, the Hospital Service Association of Western Pennsylvania, Pittsburgh, announced that 100,000 persons had been hospitalized under the plan since its inception.

The enrollment of the 71 approved plans on July 1 was 9,484,000 subscribers and dependents, a growth during the preceding quarter of 400,000. Sixty three per cent of this new enrollment was among family members. The plans with largest growth in the past quarter were: Chicago, 65,000; Philadelphia, 53,000; Boston, 48,000; Cincinnati, 46,000, and Newark, 43,000.

From England came last month the annual report of the Merseyside Hospitals Council, of which Sydney Lamb is secretary, reporting on the manner in which this contributory plan was able to withstand the holocaust of bombing. The great bulk of the records, office equipment and furniture was saved and the office moved elsewhere after Lord Street, where the council has its offices, was bombed.

Glass Construction Wins Award

In recognition of the construction of the physical therapy department of Shriners Hospital for Crippled Children, San Francisco, an award entitled "First Certificate of Honor" was presented by the National Glass Distributors Association to the Structural Glass Company of San Francisco.

Coming Meetings

- Aug. 17-21—National Medical Association, Cleveland.
- Aug. 24-28—American Dental Association, Boston.
- Sept. 9-12—American Congress of Physical Therapy, Hotel William Penn, Pittsburgh.
- Sept. 14-26—A.H.A. Institute for Hospital Administrators, International House, University of Chicago, Chicago.
- Oct. 12-16—American Hospital Association, St. Louis.
- Oct. 19-22—American Dietetic Association, Detroit.
- Oct. 26-31—American Public Health Association, St. Louis.
- November—American College of Surgeons, Hospital Standardization Conference.
- Nov. 5-6—Maryland-District of Columbia Hospital Association, Carvel Hall, Annapolis, Md.

1943

- Feb. 18-19—Texas Hospital Association, Texas Hotel, Fort Worth.
- March 10-12—New England Hospital Assembly, Hotel Statler, Boston.
- April 14-16—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.
- April 27-29—Ohio Hospital Association.













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Wood Furniture

AVAILABILITY is one thing—durability is another. Today, Eichenlaubs better wood furniture fills both requirements. In addition, it offers the hospital administrator the extra beauty, extra luxuriousness, extra quietness, and extra comfort that can be obtained only in a superior wood furniture designed and built by craftsmen trained in hospital requirements. There is a variety of Eichenlaubs better room furniture for every hospital need—ready for immediate delivery. Send for new illustrated catalog and particulars.

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For Better Furniture

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Eichenlaubs—3501 Butler St., Pittsburgh, Pa.

Send latest catalog showing furniture for Private Rooms ☐
Semi-private Rooms ☐ Bed Rooms ☐ Nurses Rooms ☐

Hospital Name _____

Your Name _____

Address _____

Hygeia announces NEW AND IMPROVED HYGEIA BOTTLE AND NIPPLE

ALL HYGEIA
ADVERTISING
SAYS—"CONSULT
YOUR DOCTOR
REGULARLY"



BABY GETS ENTIRE FEEDING

New tapered shape makes it easy for baby to get last drop of formula without tipping bottle at excessive angle.

BOTTLE: Ready today after months of research—this new improved Hygeia Nursing Bottle. Graduations applied in color, clearly visible even in dim night light. Large base makes bottle harder to tip. Improved tapered shape makes it easier for baby to get last drop of formula than with straight-side bottle. Same easy-to-clean wide mouth, with rounded interior corners—no crevices for dirt.

NIPPLE: Famous Hygeia breast-shaped nipple has patented air

vent which tends to prevent nipple collapse and reduces "wind-sucking." Sanitary tab makes nipple easier to apply without touching sterilized nipple with hand.

We urge you to inspect this new Hygeia equipment carefully. We believe you will find it has all the advantages of ordinary equipment plus the distinctive Hygeia features which will enable you to recommend it with confidence. Hygeia Nursing Bottle Co., Inc., 1210 Main St., Buffalo, N. Y.

**HYGEIA NURSING BOTTLE
AND NIPPLE**
Safer because easier to clean

For "the DURATION"...
and longer...
choose **TILE-TEX**



Private Room—South Nassau Community Hospital, Oceanside, N. Y.

DURABILITY is a "must" for floors in hospitals—especially for the "duration"—when budgets will be as limited as available materials. Tile-Tex, built from sturdy (and plentiful) asphalt and asbestos, is a rugged, long-wearing, resilient flooring.

And, even more important in these times, Tile-Tex can be had in a wide variety of colors and sizes without serious delays in delivery.

Why not survey your floor needs now—and replace worn and shabby floors with attractive Tile-Tex? Both first cost and maintenance expense are surprisingly low. Installation is swift and efficient—by skilled, approved contractors who know their business. Get the facts . . . mail the coupon now.

The TILE-TEX Company Chicago Heights, Ill.

MAIL THIS COUPON TODAY

Send me your free booklets

☐ "Floors That Endure"

☐ "Decorative Walls by Tile-Tex"

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Town..... State..... MH-8-42

Hospitals and Beauty Shops Paired in Metal Priorities

WASHINGTON, D. C.—The allocation classification system, designed to indicate readily the end use of all metals, goes into operation on July 31. Hospital needs appear under item "12.20, health equipment and supplies including personal care."

This list is a curious mixture of health and hospital items with those used by barber and beauty shops. The manufacture of braces, for example, is next to the manufacture of beauty shop equipment.

Although an order carries a low rating, it may be important. Hospital and health supplies are among the end uses for which the copper branch, for example, will seriously consider authorizing copper if the order should bear a rating lower than A-1-k.

Hartman Is Assembly Secretary

Gerhard Hartman, administrator of Newton Hospital, Newton Lower Falls, Mass., and former executive secretary of the American College of Hospital Administrators, has been chosen secretary of New England Hospital Assembly.

Salem Hospital Admits 25 "War Casualties" on Institute Field Journey

Twenty-five "war casualties" were admitted to Salem Hospital, Salem, Mass., on June 16 when a group of registrants at the second New England Institute for Hospital Administrators made a field trip to this hospital for a demonstration of "Civilian Hospitals in Total War."

Under orders from Oliver G. Pratt, the hospital director, the 25 administrators entered at the casualty receiving door where they were classified by the senior surgeon in charge and were routed for care.

One group was admitted to the shock ward, there to note blackout details and the blood bank setup. Serious surgical cases went to the operating rooms. The walking wounded were directed to the out-patient department and cases for later surgery were sent to the x-ray department and to the women's surgical ward.

As the "casualties" were routed to the various emergency services they noted blackout details in the corridors and the presence of Red Cross and other volunteers in all departments.

Following emergency treatment, the "casualties" were then routed to the director's office, which was set up as a control center. From there they went to the office of the state hospital officer, thence to the doctors' library for refreshments and questions.

Discharge was through the front door where arrangements for a light lock were noted.

Mr. Pratt is state hospital officer and has recently been appointed deputy medical director of civilian defense.

New York Hospital Unit Gets Orders

New York Hospital's Army unit reported for active duty on July 15, it was announced. To be known as the Ninth General Hospital, the same number borne by the New York Hospital in France during the last war, it will have 1000 beds and after a period in camp will be assigned to a combat area. The general hospitals serve in the communications zone of the theater of operations and treat cases passed along by units in the combat zone. Fifty-five doctors, 120 nurses and a number of nonprofessional employees are serving with the unit.

Massachusetts Has Medical Insurance

The Massachusetts Medical Society has approved a statewide plan of prepaid budgeting for medical care. The plan will be administered through a non-profit corporation called Massachusetts Medical Service, with representatives of the public, the subscribers and the medical profession on its board.



**Keep
NOISE
in its place
with J-M
ACOUSTICAL
MATERIALS**

NOISY? CERTAINLY . . .
but the right J-M Acoustical treatment can deaden this noise at its source . . . keep harsh clatter from reaching patients who need quiet surroundings.



A certain amount of noise is unavoidable in the operation of a busy hospital. Yet these sounds need never disturb your patients. The din from nurseries, nurses' stations, corridors, diet kitchens and other noisy sections can be stopped at its source . . . kept away from wards and private rooms . . . with a J-M Acoustical Treatment.

J-M Acoustical Materials are manufactured in many different types to meet every hospital requirement. All are comparatively low in cost, easily applied in new or existing buildings and require a minimum of maintenance. They meet every requirement of hospital sanitation.

For details on these modern materials, send for brochure AC-17A. Johns-Manville, 22 East 40th Street, New York, N. Y.



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PIONEERS IN SOUND CONTROL

OWEN Cabelux UNIT



**THE HOSPITAL UNIT WITH
NEW, EXCLUSIVE FEATURES THAT
PROVIDE MAXIMUM COMFORT
AND LONGER EFFECTIVE LIFE**

New Principle Innerspring for **HOSPITAL MATTRESSES**



In the new OWEN CABELUX INNERSPRING UNIT hospitals can now get qualities never before available! For the first time, they can get mattresses built around units composed of *lead-tempered steel coils permanently locked to pre-formed steel cables by Owen Silent Clips.*

Tests by Owen laboratories, independently checked by U.S. Testing Company, Inc., Test No. 12501, March 18, 1940, prove the uniform over-all resiliency and freedom from sag, lumps and noise provided by this unit. These mattresses function to perfection on Gatch frame beds.

Names and addresses of mattress makers who build quality mattresses around CABELUX UNITS will be mailed on request. Ask also for copy of new booklet—

"How To Choose A Mattress."



**OWEN SILENT SPRING COMPANY, INC.
BRIDGEPORT, CONN.**

An Associate Company of American Chain & Cable Company, Inc.



M. BURNEICE LARSON, Director

Widespread attention has been given, of late, to the program for assigning various routine duties in civilian hospitals to casually trained or untrained men and women. These individuals contribute a portion of their time in order to release the trained workers for those phases of their respective professions requiring training and skill.

While their presence in the majority of the nation's hospitals has undoubtedly solved one problem, it has created another. The men and women in key positions—department heads, supervisors—must be prepared to teach as well as direct. They must be on the alert constantly lest a minor defect in routine performance lead to a more serious error.

If in addition to special training in medicine, nursing, hospital administration, laboratory or x-ray technique, bacteriology, pharmacy, you have a gift for explaining your work clearly and concisely to another, you can make a vital contribution to the continued efficiency of civilian hospitals at this time. We should like to know who you are, the approximate date on which you might be available for relocation, your professional interest. Forms have been prepared on which you may outline your qualifications and requirements for our guidance in suggesting the opportunities for service which should interest you most. A postal request will bring one to you by return mail—but be sure to mention the field in which you have had special preparation that we may send the form proper for you!

Our service, as you probably know, is nation wide—extending even into combat zones. It is confidential. May we hear from you soon.

M. BURNEICE LARSON

Director, The Medical Bureau

PALMOLIVE BUILDING

CHICAGO

Tire Rationing Rules Modified for Doctors, Public Health Nurses

WASHINGTON, D. C.—An amendment to the tire rationing regulations passed last month tightens certain requirements, relaxes others. The amendment requires that a vehicle operated by a physician or surgeon must be used *exclusively* (rather than *principally* as before) for professional services to be eligible for tires and tubes.

Even under the new requirements, however, if it is necessary for the applicant to answer emergency calls as a part of his practice, he may be issued a certificate to enable him to use his car between his home, his office and hospitals.

The amendment changes the designation of nurses eligible for tires from "visiting nurse" to the broader term, "public health nurse."

To Direct Private Hospital Group

Officers of the Association of Private Hospitals, Inc., for the coming year are: president, Dr. E. John Dolan; vice presidents, James Fitch, Dr. Max Rohde, Dr. Albert Fritz and Dr. Alexander Kaye, and secretary, Oscar Gottfried.

New Funds for Fluorescein Research

Further research in the use of fluorescein as a means of measuring the adequacy of blood supply to the various parts of the body will be made at Flower and Fifth Avenue hospitals, New York, following a grant of \$3400 by the Markle Foundation. Fluorescein, a harmless dye, when injected into the blood stream, gives off a greenish glow if exposed to ultraviolet light. By this method surgeons are said to be able to determine with accuracy while the patient is on the operating table whether or not affected organs should be removed or at just what point amputation may be necessary.

Flint-Goodridge on War Medicine

Thirty-six physicians from seven states attended the seventh annual postgraduate course for physicians at Flint-Goodridge Hospital of Dillard University from June 22 to July 3. Negro physicians serving on the faculty are chiefs of departments at Flint-Goodridge Hospital, Dr. Rivers Frederick in surgery and Dr. Logan W. Horton in ophthalmology and otolaryngology. This year, because of the war emergency, the lecturers laid much emphasis on war medicine and surgery and on the handling of catastrophes.

City to Help Pay Hospitals for Civilian War Casualties

The hospitals and city of Oakland, Calif., have entered into a joint contract whereby the city, in consideration of the fact that the hospitals agree to maintain emergency services for care of civilian war casualties, has agreed to pay these hospitals the difference between the \$3.75 per day paid by the federal government under O.C.D. and the actual cost of service.

The costs of the hospitals cannot exceed the charges regularly made by such hospitals for industrial accident cases. All bills have to be approved by the city manager.

This is the first such agreement that has been publicly reported in the hospital press and may set the pattern for similar agreements in other cities, particularly in the coastal area.

State Association Starts Bulletin

The Illinois Hospital Association is now publishing a news bulletin, the first issue being the one for July-August. Mrs. Florence Slown Hyde is the editor and the editorial committee consists of Charles A. Lindquist of Elgin, Victor S. Lindberg of Waukegan and Rev. Joseph A. George of Chicago.

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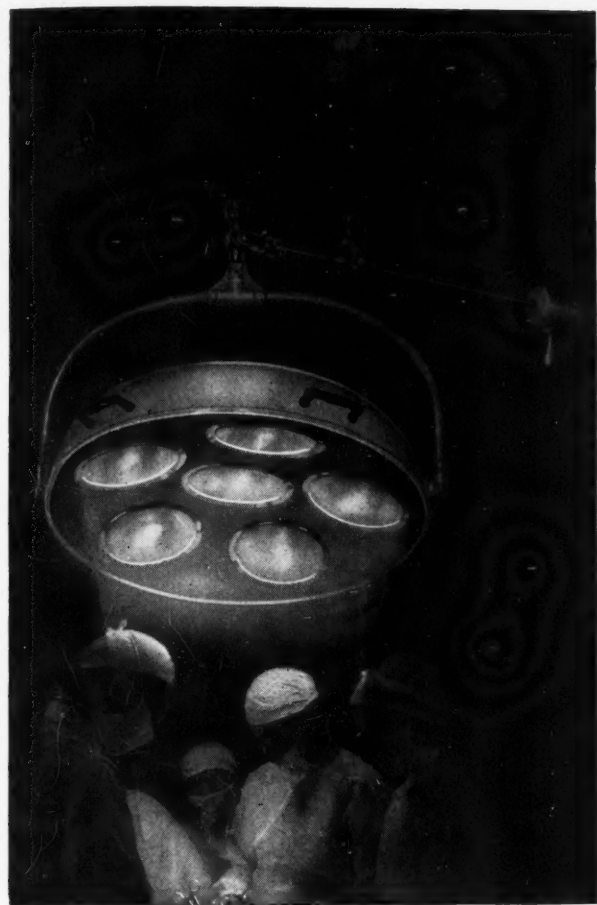
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COUNTERBALANCED OPERATING
LIGHT—ADJUSTABLE
TO ANY POSITION**



PLUS MANY IMPORTANT FEATURES

A light that is preferred by many hospitals. Six individual light sources, coolbeam heat filters, dust-tight construction, universal focus of light beam to eliminate readjustment of the light.

Can be set at any angle with fingertip ease. Rotates in a complete circle. Adjustable in height. 42" diameter.

WRITE FOR COMPLETE CATALOG

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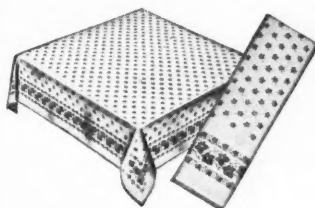
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Job Opportunities for Women in Hospitals Are Summarized

Opportunities for women in the medical, hospital and related fields are summarized and described in a recent publication by the Illinois Office of Public Instruction.

The publication was prepared by a special medical committee of the Women's Executive Committee on job opportunities for women. The special committee was headed by Mabel W. Binner, administrator of Children's Memorial Hospital, and Edna H. Nelson, administrator of Women and Children's Hospital, both of Chicago.

The bulletin describes the jobs open to women and the qualifications for these positions in pharmacy, medical records, medical social service, radiology, hospital administration, physical therapy, accounting, housekeeping, dentistry, occupational therapy, food service, pathology and medicine. Job clinics for girls have been held in Chicago and plans are under way to hold similar clinics in other parts of the state.

Chicago Blue Cross Plan Moves

Chicago's Plan for Hospital Care has recently moved to new and larger quarters in the Merchandise Mart, Robert T.

Sherman, president of this Blue Cross plan, announced recently. A large section of the new quarters houses the plan's "unit system" of servicing its more than 400,000 members. This system, now much imitated, services a specified number of firms and organizations enrolled, providing a much closer contact between the member and the staff employees handling his account.

Battle Creek Sanitarium Not Sold

The Battle Creek Sanitarium, Battle Creek, Mich., has not been sold, contrary to newspaper accounts. Merely one of its large buildings and two or three smaller ones have been transferred to the government for Army use. The remaining buildings will easily accommodate several hundred patients, Dr. John Harvey Kellogg announces.

Brooklyn Methodist Opens Pavilion

The new Buckley Pavilion of Methodist Hospital, Brooklyn, N. Y., has been opened following some delays in receiving materials. The nine story unit, which adds 144 beds and cost \$1,000,000, was dedicated recently by Bishop Francis J. McConnell of the New York area. The pavilion stretches a block long and is said to be equipped to handle any type of emergency war service.

N. J. Acts to Accelerate Standard Pharmacy Course

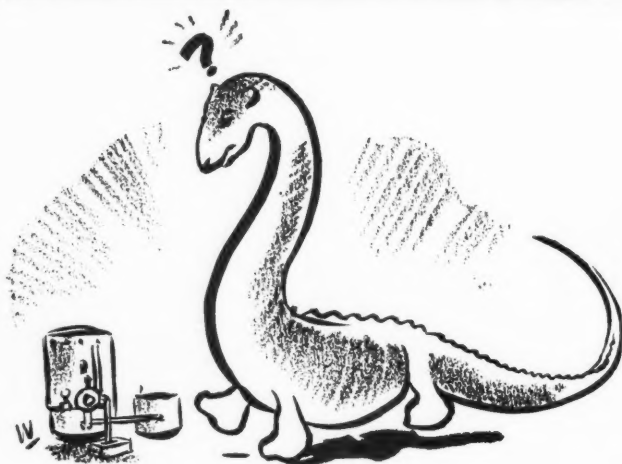
By recent action of New Jersey's board of pharmacy, deviation from established standards in pharmaceutical education will be considered only to the extent that the usual two months' intervention between the closing and opening of each academic year of the four year pharmacy course may be abolished between the present sophomore and junior and junior and senior courses.

This will effect an acceleration of the course for students in the upper classes and will be considered entirely as a temporary expedient to be abolished immediately after the war.

Yale Unit Mobilized July 15

The Yale unit, U. S. Military Hospital No. 39, including 48 physicians, seven dentists, 103 nurses and civilian specialists, was mobilized on July 15 for active war duty. The hospital unit is designed to accommodate 1000 patients. The new 39th General Hospital is a stationary hospital in the rear of a combat zone, will probably be used for foreign service and is much larger than Mobile Hospital No. 39, the first American hospital unit to land in France during World War I.

DOUBLE your Softener Capacity!



Present water softeners must stand up for many years to come, must meet the challenge of ever-increasing demands for soft, iron-free water. Keep present equipment at peak of production by replacing greensand with Refinite Natural High-Capacity Zeolite. It will DOUBLE your softener output without additional tank equipment.

Water treatment engineers praise Refinite for its extraordinary durability . . . point to scores of Refinite beds still functioning at top efficiency after 25 years of service.

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Lessen Human Suffering! Raise War-time Efficiency! Save Money! With This Newest 2-in-1 Crescent Creation!

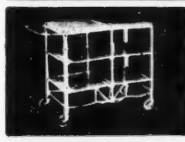
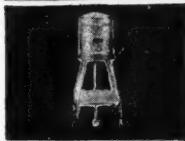
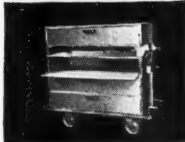
Now, the Crescent Electric Stupe Kettle can easily be made to serve TWO important functions—at small added investment—simply by using the new Crescent Inhalator accessory.

Electric Stupe Kettle. Hot compresses perfectly prepared at patient's bed-side. Foot operated cover leaves nurse's hands free. . . . Insulated Kettle. Seamless heating chamber. Thermostatically controlled—500 watt heating unit. Red pilot light. Sturdy tubular frame. Swivel casters. Silvertone, water-proof lacquer, finish.

Inhalator Accessory. For relieving lung or head congestion or coughing. Also respiratory ailments among children. Excellent humidifier in nursery. . . . Quickly brought into use. As simple as putting lid on a kettle—and "plugging in." Soon the healing, medicated vapors flow. Operates 12 hours without attention. . . . Polished steel lid—lipped to fit snugly into Electric Stupe Kettle top. Extension of flexible metal tubing, riveted to lid and hard fiber nozzle.

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West's Vaposector fluid is a proven insecticide that kills roaches and other insect pests. It has the highest degree of lethal effectiveness, yet is harmless to food and fabrics when used according to directions.

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Names in the News

Administrators

Fred M. Walker, administrator of Charlotte Memorial Hospital, Charlotte, N. C., from November 1939, when the new hospital was being constructed, until he resigned last February, has taken over the management of Grady Hospital, Atlanta, Ga. Mr. Walker will co-operate with **Dr. Russell H. Oppenheimer**, dean of the school of medicine of Emory University, in the medical school's teaching program. A charter fellow of the American College of Hospital Administrators, Mr. Walker began his hospital work when he was stationed at Walter Reed Hospital, Washington, D. C., during the first World War.

G. R. Harris, formerly superintendent of public health for the city of Detroit, has been appointed administrator of the Herman Kiefer Hospital, Detroit.

Mrs. Oneta M. Rice, R.N., is superintendent of Woodford County Memorial Hospital, Versailles, Ky.

Ina Garwood has been named superintendent of the Lenawee County Tuberculosis Sanatorium, Adrian, Mich.

Sister M. Claran has succeeded **Sister M. Giles Phillips** as administrator of St. Joseph's Hospital, Hancock, Mich.

Sheila Neimark has assumed her duties as head of Monticello Hospital, Monticello, N. Y.

Dr. Robert L. Yeager is the new superintendent of Summit Park Sanatorium at Pomona, N. Y.

E. Augusta Lamberger, formerly director of nurses at Homestead Hospital, Homestead, Pa., has been named administrator of the hospital.

Almira Bowes is the new superintendent of the National Stomach Hospital, Philadelphia.

Lillian Nash, R.N., has taken over the superintendency of Gardiner General Hospital, Gardiner, Me.

R. Doris Edwards, formerly assistant superintendent of nurses at Chapin Hospital, Providence, R. I., is the new administrator of South County Hospital, Wakefield, R. I.

Dr. Edward J. Nagoda has been appointed head of the Utah State Tuberculosis Sanatorium, Ogden. Prior to his appointment, Doctor Nagoda was acting

superintendent and medical director of Lakeview Sanatorium, Madison, Wis.

Dr. Carl Apfelbach has been named medical director of Presbyterian Hospital, Chicago. Doctor Apfelbach will continue with his work as the hospital's attending pathologist in addition to his new duties.

Roland Scott resigned his position as head of Burnham City Hospital, Champaign, Ill., effective July 15. Mr. Scott formerly was connected with Evangelical, Grant and Michael Reese hospitals, all of Chicago.

Louise Harkey, R.N., succeeds **James R. Felts** as superintendent of Cabarrus County Hospital, Concord, N. C. Mr. Felts has joined the armed forces.

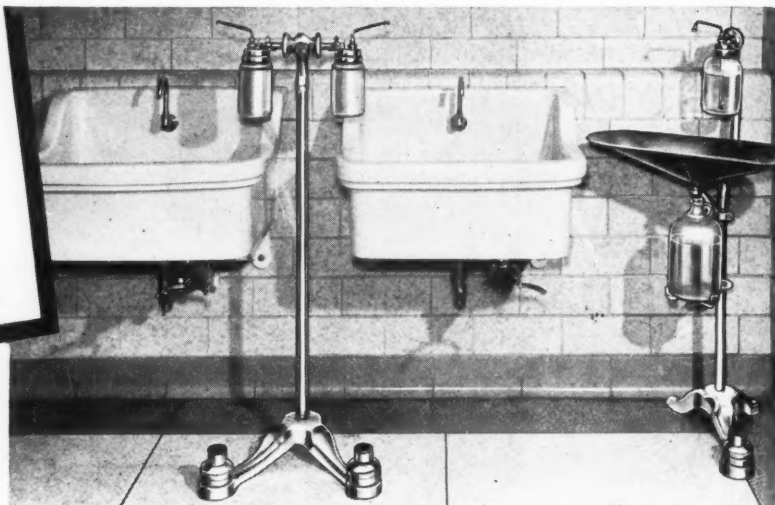
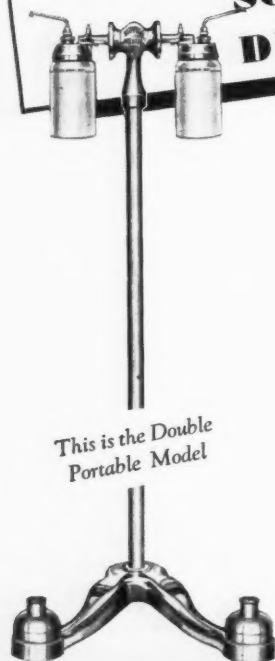
F. M. Monahan is the new business manager at Lakeview Hospital, Suffolk, Va.

Sallie Brown succeeds **Thelma Davis** as superintendent of Thomison Hospital, Dayton, Tenn.

Dr. Charles E. Martin, medical director, Albany Hospital, Albany, N. Y., has been appointed medical director of the Bell Telephone Laboratories, New York.

C. L. Allen has been appointed superintendent of the Cherokee County Hospital, Gaffney, S. C., to take over the position left when **W. W. Lowrance** entered the armed services.

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SOAP and
DISPENSERS



YOU add to efficiency and subtract from the cost through the perfect teamwork of the new improved Septisol Dispensers and Septisol Surgical Soap. There is no better combination for scrub-up room technique.

The new improved Septisol Dispensers regulate the flow of soap by feathertouch foot control—releasing as much—or as little soap—as desired. More sanitary. More economical. No wasteful dripping. Last a lifetime because no moving parts—nothing to wear out. 3 models—double portable, single portable and wall type, all attractively finished.

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Address inquiries regarding orders, shipments, etc., to any of the above distributors or direct to

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A Sedgwick Hand Power Hospital Elevator assures dependable "stand by" equipment to supplement regular service in the movement of stretchers, chairs, mortuary cases, etc., during the period of emergency, especially when fire threatens. Standard car sizes and capacities to meet all normal needs.

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A Sedgwick Hand Power Dumb Waiter will provide movement of food and supplies between two or more floors. Capacities up to 500 lbs.

Sedgwick hand power equipment is noted for its ease and safety of operation, because designed by experienced engineers and built of best available material by precision methods. Present conditions warrant your fullest consideration of equipment of this character to safeguard and maintain service when normal facilities fail.

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Please send catalog. I am interested in

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P. M. Clauser, formerly purchasing agent of Parkland Hospital, Dallas, Tex., has assumed his new duties as superintendent of the Masonic Hospital, El Paso, Tex.

C. D. Ward is the new administrator of Pitt General Hospital, Greenville, N. C.

A. E. Abernethy has assumed his duties as head of the Lawrence County General Hospital, Ironton, Ohio.

Frances P. West, R.N., formerly superintendent of the Middlesex Hospital, Middletown, Conn., is now administrator of Nantucket Cottage Hospital, Nantucket, Mass.

Isabel V. Cameron is the superintendent of Illini Community Hospital, Pittsfield, Ill.

Mrs. Genevieve R. Jeffrey, R.N., has been appointed superintendent of the Central Michigan Community Hospital, Mount Pleasant, Mich., which is nearing completion.

Dr. B. B. Wells, formerly clinical pathologist at University Hospital, Little Rock, Ark., has been named administrator of the institution.

Dr. Edward Ross resigned from his position as managing officer of Alton State Hospital, Alton, Ill., to become head of Manteno State Hospital, Manteno, Ill.

Dr. John D. Foley recently was appointed superintendent of Lake County General Hospital, Waukegan, Ill., succeeding **Dr. Charles Lieber**.

E. E. Opdyke was appointed administrator of Chippewa County War Memorial Hospital, Sault Ste. Marie, Mich., on July 15.

Louis Miller, formerly assistant director of Mount Sinai Hospital, New York City, has been named administrator of Jewish Memorial Hospital, New York City.

Ellen L. Stahlnecker, who was superintendent of nurses at the Herman Kiefer Hospital, Detroit, for sixteen years, was named to head Children's Hospital, Akron, Ohio.

Eva Y. Gladue, R.N., obstetrical supervisor of St. Barnabas Hospital, Newark, N. J., recently was appointed assistant superintendent of the J. C. Blair Memorial Hospital, Huntingdon, Pa.

Ava Crowder has been named to succeed **David W. Finch** as business manager of Mary Elizabeth Hospital, Raleigh, N. C.

Betty Gessler is the new superintendent of Belding City Hospital, Belding, Mich.

Gladys Phipps succeeds **Jean S. Cole** as head of the Florence Crittenton Home, Washington, D. C.

Honor Roll

Hospital administrators and assistant administrators serving in the armed forces:

U. S. Army

Lawrence Bright, City Memorial Hospital, Thomasville, N. C.
David W. Finch, Mary Elizabeth Hospital, Raleigh, N. C.
Lee C. Gammill, Baptist State Hospital, Little Rock, Ark.
R. A. Neblett, M.D., Neblett Hospital, Canyon, Tex.
J. Stuart Staley, M.D., Homeland Hospital, Marion, Va.

Royal Canadian Army Medical Corps

Florence J. Cameron, R.N. Peigan Indian Hospital, Brockton, Alta.
M. R. Caverhill, M.D., Vancouver General Hospital, Vancouver, B. C.
Helen L. Downs, R.N., Davidson Union Hospital, Davidson, Sask.
Thelma Finlayson, R.N., Red Cross Hospital, Bracebridge, Ont.
Anne Halabuz, R.N., Brock Union Hospital, Arcola, Sask.
Blanche G. Herman, R.N., Western Division, Montreal General Hospital, Montreal, Que.
Ethel M. Jamieson, R.N., Central Butte Hospital, Central Butte, Sask.
Helen M. Jordan, R.N., Queen Victoria Memorial Hospital, North Bay, Ont.
Dorothy J. MacKay, R.N., Manitoba School for Mental Defectives, Portage La Prairie, Man.
Dorothy I. MacRae, R.N., Anson General Hospital, Anson Junction, Ont.
Mary I. McLellan, R.N., Union Hospital, Shaunavon, Sask.
Kathleen Mullen, R.N., United Church Hospital, Hearst, Ont.
Jean S. Taylor, R.N., Cold Lake Hospital, Cold Lake, Alta.

Royal Canadian Navy

H. G. Farish, M.D., Vancouver General Hospital, Vancouver, B. C.

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Besides Mrs. Brown's
new baby!



YES INDEED! A brand-new, sanitary wall covering! And if you can believe hospital superintendents everywhere, it will help greatly to keep this nursery "hospital-clean." That means a lot to Mrs. Brown's baby—and other youngsters, too.

Linowall promotes sanitary conditions wherever it is used. With this flexible wall covering, corners can be made smooth and rounded, to prevent dust and dirt from accumulating.

Because Linowall is washable, mild soap and water will wipe it free of spots and stains in a jiffy. That means easy and inexpensive maintenance.

And in addition, Linowall is durable. When you use it to cover old walls or new ones, you can count on its factory-lacquered finish to last a long, long time.

Armstrong's Linowall is quickly and inexpensively installed over any sound plaster area. It's available in a wide range of colors. For full details, write to the Armstrong Cork Company, Floor Division, 1231 State Street, Lancaster, Penna.



THIS NURSERY has walls that will afford clean, sanitary service for years to come. It's the St. Nicholas Hospital nursery in Sheboygan, Wisconsin, and the walls are covered with a soft shade of Pattern 708 Primrose Linowall.

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**Made specially for hospital use,
it's unsurpassed for purity . . .
for mildness . . . for economy!**

The three major requirements of a soap for patient care are purity, mildness, and economy. Colgate's Floating Soap meets all three, *because in its development, hospital needs were given first consideration!*

In purity, Colgate's Floating meets the highest hospital standards. Nurses and patients agree that it is exceptionally mild and kind to the skin. And in cost, hospital superintendents find Colgate's Floating an agreeable surprise!

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For use in private pavilions, and particularly for women patients, we suggest Cashmere Bouquet. A fine, white, hard-milled soap, it is famous for its rich, creamy lather . . . its delicate, lingering perfume! Available in a variety of miniature sizes.



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Colgate-Palmolive-Peet Co.
Industrial Department Jersey City, N. J.

Mrs. Loretta Smith has been appointed superintendent of the new Morrison Hospital, Morrison, Ill.

W. C. Swenson has taken over her new duties as superintendent of Samaritan Hospital, St. Paul, Minn.

Maude N. Branscome, superintendent of nurses at Rockingham Memorial Hospital, Harrisonburg, Va., has been appointed superintendent of Lynchburg General Hospital, Lynchburg, Va., to succeed **Hazel M. Kinzer**.

Mrs. Margaret Kirkpatrick has been named superintendent of Jane Lamb Hospital, Clinton, Iowa.

Rhode Carroll, R.N., succeeds **Nell Hammond** as superintendent of Hopkins County Hospital, Madisonville, Ky.

Dr. Harry Frederick Hoffman, assistant superintendent and clinical director for nearly thirty years at Allentown State Hospital, Allentown, Pa., succeeded **Dr. Henry Irwin Klopp** as head of the institution on July 1. Doctor Klopp had completed thirty years of service to the institution, which he had headed since its opening in 1912.

Mrs. Adelaide Lewis has been appointed superintendent of Lillie-Duke Hospital, Goose Creek, Tex. Mrs. Lewis replaces **Maggie McConathy**.

Mrs. Dorothea Stinson Graham, R.N., has been named assistant superintendent

of New Hampshire Memorial Hospital, Concord, N. H.

Mae Cleverly, who has been serving as acting superintendent of Tobey Hospital, Wareham, Mass., since June 1941, recently received a permanent appointment to that position.

Anna Wild, for the last sixteen years assistant superintendent of Stamford Hospital, Stamford, Conn., recently assumed the duties of superintendent of Mount Desert Island Hospital, Bar Harbor, Me.

Department Heads

Lorna Robinson, assistant superintendent of nurses in charge of obstetrics at Cook County Hospital, Chicago, has been appointed superintendent of nurses at Rockford Hospital, Rockford, Ill., to succeed **Florence Mortenson**.

Dr. William L. Waskow, radiologist at Rockford Hospital, Rockford, Ill., resigned recently to serve with the Chicago St. Luke's hospital unit. Doctor Waskow has been commissioned a captain in the Army.

Dr. Theresa I. Lynch has been appointed director of nurses by the board of managers of the University Hospital of the University of Pennsylvania. Doctor Lynch is recognized as a leading authority on communicable disease nurs-

ing and is the author of a book on that subject, which was published recently.

Meta M. Summers, R.N., assistant educational director and instructor for the past five years at St. Anthony Hospital School of Nursing, Terre Haute, Ind., left July 1 for Our Saviour's Hospital, Jacksonville, Ill., where she is to be director of nursing education.

Rose Chorney has been appointed director of nursing service at the Colorado State Hospital, Pueblo, succeeding **Isabel M. Reardon**. Miss Reardon will enroll at Cornell University for a course in hospital administration.

Miscellaneous

John Ransom, executive secretary of the Hospital Council of New York, has resigned.

R. Starr Parker, chief engineer of St. Luke's Hospital, Cleveland, and co-editor of the plant operation department of THE MODERN HOSPITAL, has been granted a leave of absence for the duration. Mr. Parker has been commissioned a captain in the repairs and utilities division of the corps of engineers, U. S. Army.

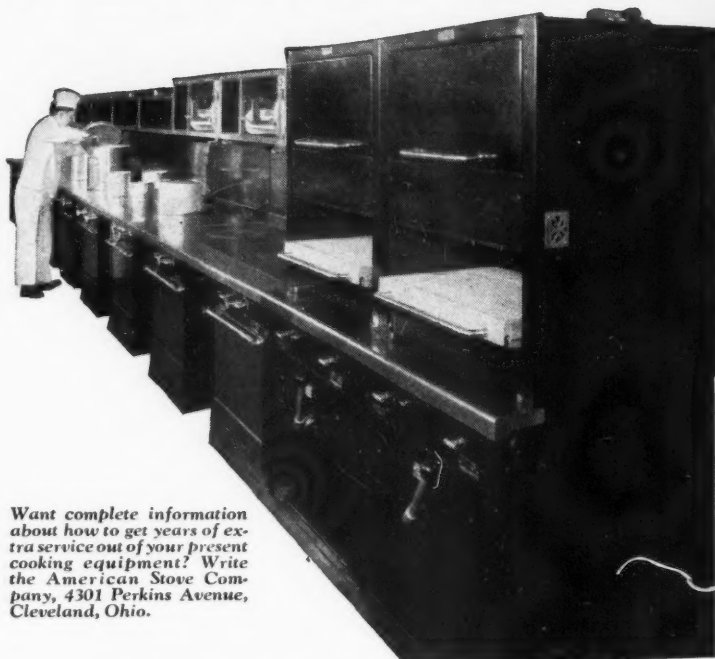
Deaths

Dr. Charles Bernstein, who was superintendent of Rome State School for Mental Defectives, Rome, N. Y., for thirty-eight years, died recently.

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"**B**USINESS as usual" was one of the casualties at Pearl Harbor. So we shed a hasty tear and went on to more important things. The American Stove Company is proud that its men and machines are busy turning out vital war materials. And insofar as Magic Chef Heavy Duty Gas Cooking Equipment is concerned, the military forces of the U. S. have first call.

But there are hospital cooking needs that are essential to the victory program. If your needs fall within that category, you'll find Magic Chef Heavy Duty Gas Cooking Equipment the best and most satisfactory answer to your cooking problem. If you need help to keep cookin', write or phone the nearest American Stove Company branch today . . . or get in touch with your cooking equipment supplier.



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DIRECT APPLICATION OF SULFANILAMIDE (FLINT)

to —

WOUNDS

LACERATIONS

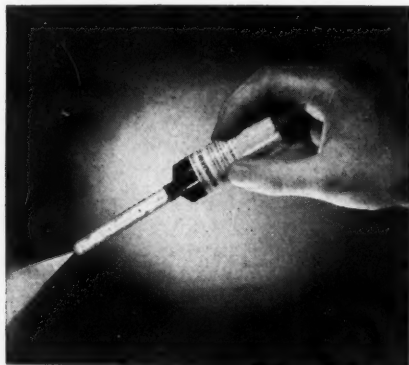
BURNS

ABSCESES

COMPOUND FRACTURES

OTOLARYNGOLOGY

Continued references in the literature* suggest the value of topical application of Sulfanilamide in the above conditions.



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For greater convenience in applying locally, Sulfanilamide (Flint) is available in 1/2 oz. insufflator tubes.

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*Local Use of Sulfanilamide, Surgery, 9:825-996, June, 1941; The Use of Sulfanilamide in Compound Fractures, Virg. Med. Monthly, p. 237, May, 1942; Local Use of Sulfanilamide, Ind. Med., p. 493, Oct., 1940; Sulfonamide Therapy as an Aid to Surgery, S. G. & O., p. 307, Feb. 1942; Sulfanilamide and Related Compounds in Wound Infection, Wis. Med. J., 40:115, Feb., 1941; The Local Implantation of Sulfanilamide in Compound Fractures, So. Med. J., p. 449, May, 1940.

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The graph displays two data series over a five-year period. The 'GOVERNMENTAL' series starts at approximately 84% in Jan 1937, peaks at 92% in Jan 1939, and ends at 78% in Jan 1942. The 'NON-GOVERNMENTAL' series starts at approximately 71% in Jan 1937, peaks at 76% in Jan 1938, and ends at 78% in Jan 1942. Both series show significant seasonal fluctuations and a general downward trend after 1939.

Year	Month	Governmental (%)	Non-Governmental (%)
1937	Jan	84	71
1937	Jul	85	74
1937	Jan	80	70
1937	Jul	80	69
1937	Jan	85	72
1937	Jul	85	73
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937	Jul	82	68
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1937	Jan	82	69
1937	Jul	82	68
1937	Jan	85	71
1937	Jul	85	72
1937	Jan	84	71
1937	Jul	83	70
1937	Jan	82	69
1937			

ported from June 15 to July 13 cost \$13,241,000, bringing the year-to-date total to \$94,600,000 as compared to \$69,600,000 last year. But war has stopped work on \$3,500,000 of this.